CAREGIVING BABY BOOMER MEN: AN EXPLORATION OF THE IMPACT OF

DISCRIMINATION ON PSYCHOLOGICAL DISTRESS AND

CAREGIVING ROLES

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BY

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DEDICATION

I would like to thank my parents, sister, nephew, and friends for allowing me the space and time to focus on this adventure.

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ABSTRACT

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In order to further current understanding of the diversity and complexity of caregivers, this study examined the relationship between Baby Boomer men's perceptions of discrimination based on their current caregiving roles and their psychological distress. Aspects of caregiving roles assessed included hours a week providing care and assistance providing activities of daily living. Additionally, the study examined the use of respite and perceptions of social support on psychological distress. Using Mechanical Turk and Facebook to recruit participants, a sample of 154 men participated in the online survey. The results of a multiple regression analysis indicated that this cohort of men reported both psychological distress and discrimination, yet discrimination did not impact distress or caregiving roles. There was also no evidence that access to respite and social support moderated psychological distress for caregiving men. While none of the hypotheses were fully supported, the current research contributes to understanding the amount and diversity of caregiving that Baby Boomer men are providing. Avenues for potential future research were discussed.

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CHAPTER I

INTRODUCTION

Baby Boomers are a defined cohort with a shared zeitgeist. The Baby Boomers (BBs) in the United States (U.S.) have lived through many radical social changes, including changing attitudes about race (the civil rights movement and changes in legislation related to racial quality), about gender (the second wave of the women's movement), and about sexual orientation (the Stonewall riots and legislative changes in gay rights). Baby Boomers have also lived through the Vietnam and Iraq wars, increasing attention given to environmental issues, increasing human longevity, the advent and progression of AIDS , and the 9/11 terrorist attack on U.S. soil (Longino Jr., 2005; Shippy, Cantor, & Brennan, 2004). The BB cohort has shown many strengths and flexibilities during the past few decades. BBs are currently at a time of multiple transitions related to aging, including changes in both work/retirement and in family roles.

Statement of Problem

When reviewing the research from the last decade, it is evident that the BB cohort is providing the majority of informal family care. For example, the average age for those caring for elderly parents is 55 (del-Pino-Casado, Frías-Osuna, Palomino-Moral, & Martínez-Riera, 2012; Foley, Tung, & Mutran, 2002; Holland, Thompson, Tzuang, & Gallagher-Thompson, 2010; Perrig-Chiello & Hutchison, 2010; Piercy & Chapman,

2001); the age of caregivers providing care and support for adult children living with parents ranges from 40 to 60 (Raphael & Schlesinger, 1993); and the average age for grandparents caring for grandchildren is 60 (Crewe, 2006; Hayslip, Emick, Henderson, & Elias, 2002; King, Kropf, Perkins, Sessley, Burt, & Lepore, 2009; Letiecq, Bailey, & Kurtz, 2008; Thiele & Whelan, 2008). More BB men are becoming caregivers to keep up with current social changes impacting the pool of available family caregivers, such as changes in the economy and employment, shifting family structures, and changing insurance structures that impact medical costs (Laidlaw & Baikie, 2007; Schulz & Binstock, 2006).

Aging in the U.S. is an increasingly expensive phenomenon; some of the financial burden may be transmitted to younger generations. Family caregiving for elderly relatives is a growing concern in an aging society. The annual cost to care for an elderly individual averages $75,000, with little cost difference between home care and a private room at a nursing home (MetLife Mature Market Institute®, 2005). When elderly parents are in need of assistance, BB men reported stress associated with deciding whether to continue working or retire (Bonnet, Cambois, Cases, & Gaymu, 2011; Malone, Beach& Langeland, 2011). The financial impact of caregiving can greatly influence different work-life conflicts for caregiving men. When men are responsible for elder care, they are more likely to hire some professional assistance with care duties than women (Bonnet et al., 2011). Baby Boomer men have primarily been socialized to work outside of the home more than provide care (Black, Gauthier, Dalziel, Keren, Correia,

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Hew, & Binder, 2010; Bonnet, Cambois, Cases, & Gaymu, 2011; McKee-Ryan, Song, Wanberg, & Kinicki, 2005), yet many are finding themselves at intersections of work, retirement, and family members in need of care. Caregivers facing the decision to continue to work or retire have to evaluate family income, wealth, family commitment and need, and resources, including interpersonal support (Meriac, Woehr, & Banister, 2010). While many studies exist on BBs' work-family conflict, often these studies treat the cohort as homogeneous and do not incorporate diversity factors, such as socio-economic status, race, sexual orientation, and familial obligations (Armstrong-Stassen, 2001; Harper& Shoffner, 2004; Meriac et al., 2010; Mutchler, Burr, Massagli, & Pienta, 1999; Wang, 2007).

Balancing obligations between family and financial needs becomes even more complicated for BB men when caregiving was not planned, such as when adult children return home or when BB men become grandparents raising grandchildren. Traditional divisions of labor and gender roles in the U.S. may also impact men's caregiving role stress. Men have historically and culturally not been primary caregivers or been involved in caregiving roles. For example, among Puerto Rican and Dominican caregivers, only 31% of men assisted their wives who were the primary caregivers of grandchildren (Burnette, 1999). When men do provide care they do so differently than women. In a national survey, the National Alliance of Caregivers with the American Association of Retired Persons (NAC/AARP, 2009) found caregiving men were less likely to provide activities of daily living care, with only 24% of men helping a loved one get dressed and

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16% helping with bathing a care recipient. Additionally, the survey found those without resources to assist in caregiving reported more psychological distress. In a national survey, "51% of those who provide care for 21+ hours rate their stress as high vs. 24% of those providing no more than 20 hours of care" (NAC/AARP, 2009, p.50).

Research that accesses marginalized populations found that lower education and lower income families prefer family care, while those with more education and income report higher preference for non-family care (Foley, Tung, & Mutran, 2002).Often men were mentioned as a subgroup to the primary and majority of caregiving women. Most research on caregiving in older populations that has mentioned caregiving and men has focused on spousal caregiving dyads (Adams, Aranda, Kemp, & Takagi, 2002).The current researcher sought to explore intergenerational and multigenerational caregiving in a more inclusive study of family caregiving than previous research on so called sandwich generations, which are usually loosely defined as adult children who simultaneously are caring for both their own children as well as their elderly parents (Hammer & Neal, 2008; Miller, 1981).

The life and role transitions of BB men collide in multiple ways and also intersect with gender roles and discrimination. All BB men are at risk for ageism, but BB men vary in their risk for and impact from classism, heterosexism, and racism. Discrimination is known to cause psychological distress (e.g., Hulko, 2009; Witten, 2009). The ability for a BB man to provide care while he is also facing daily discrimination has yet to be studied. Research does not currently exist on BB men possessing one or more

marginalized identities, who negotiate caregiving and discrimination with finite

resources, including functional levels of stress, limited hours each day and week, and

various levels of financial flexibility.

Research Question

The current dissertation asked the broad question: What impact does discrimination have

on the relationship between intergenerational caregiving and psychological distress for

diverse Baby Boomer men?

Rationale for Study

The current study was important for a number of reasons. Caregiving roles are

diverse and complex. More men are becoming caregivers in the U.S (Stenberg-Nichols

& Junk, 1997). Simultaneously; the U.S. is also experiencing a racial/ethnic

demographic shift in its population (U.S. Census Bureau, 2008). BB men are

experiencing internal changes in aging and external changes in their roles in employment

and their aging families. Stenberg-Nichols and Junk (1997) found substantial numbers of

BBs were responsible for aging parents and financially dependent children. These

caregiving roles impact physical and psychological functioning in a number of positive

and negative ways. In the current study, the researcher explored psychological distress

and factors that contribute to and attenuate that distress for BB men who are also

caregivers.

For BBs, successful aging should be measured by more than just an absence of

disease, but rather by a holistic understanding of how current context is negotiated. The

present study examined the current discrimination and the family caregiving context of

BB men in addition to psychological distress. Multiple barriers exist for BBs with

marginalized identities; some of these marginalizations include increasing age, non-

heterosexual sexual orientation, non-conforming gender presentation, lower income, and

non-racial majority statuses. Different aspects of identity can profoundly shape the

experience of family caregivers (Price, 2011). Ageism is present in every aspect of

society, including employment and even among helping professionals (Nelson, 2005).

All BB men are at risk for ageism (Schulz & Binstock, 2006; Witten, 2009). However,

many BB men also face other forms of discrimination based on various minority status

identities. Research has found relationships between high self-reported experience of

racial discrimination, poor health outcomes, and lower socioeconomic position, including

limited education, lower employment status, and depressed wages (Krieger, Smith,

Naishadham, Hartman, & Barbeau, 2005; Williams, Yu, Jackson, & Anderson, 1997).

All of these factors are impacting BB men and their families at the same time, yet had not

been examined together.

Defining a set cohort, such as BBs, allows a possibility that all the participants

can explore some aspect of discrimination, such as ageism. While multiple forms of

discrimination exist and can compound psychological distress, such as ablism, healthism,

and/or bodyism (Nelson, 2005), including all forms of discrimination was beyond the

scope of this research project. The current study attempted to address the racial/ethnic,

socio-economic, and heteronormative assumptions. In and of themselves, racism,

classism, and heterosexism have reliably established links to psychological distress (e.g., Albert, Schulz, & Colombi, 2010; Díaz, Ayala, Bein, Henne, & Marin, 2001; Federal Bureau of Investigation, 2011; Herek, 1990; Lee & Ahn, 2013), but had not been examined in relationship to BB men's caregiving.

The theoretic framework to be used to explain these research ideas was feminist gerontology, which recognizes the importance of intersectionality and provides a useful structure to encompass the marginalized identities and caregiving roles of BB men (Calasanti, 2004; Iwasaki, Bartlett, MacKay, Mactavish, & Ristock, 2008; Paoletti, 2002). A feminist perspective was used in the review of existing research and in composing the dissertation question. Given that existing research may not be reliable or applicable because of weak or flawed research designs, or lack of a theoretical framework, the use of feminist gerontology as a base from which to conceptualize this study was important. In a meta-analysis of caregiving research, Dilworth-Anderson, Williams, and Gibson (2002) found the use of "nontheoretical approaches, nonprobability samples, and inconsistent measures..." in research studies has limited the understanding of caregiving among diverse populations (p. 237).

In summary, examining multiple factors together in a study of BB men's caregiving, within the framework of feminist gerontology, has contributed to the professional literature in a unique way, addressing gaps in the research landscape, particularly in terms of diversity concerns. The information gleaned from this study has useful applications in psychotherapy and future research.

Definition of Terms

While conducting an in-depth literature review, this reviewer found many differences in definitions in existing research on caregiving and caregivers. These differences included differences in the definitions of family as well as differences in language used to define marginalized populations. For example, different researchers often used different terminology to describe the complexity of sexual orientation and gender presentation, or omit altogether any option for these populations to self-identify. Variable or inconsistent language usage can be problematic for comparing and applying research. For example, some researchers explored the relationships between gay men, while others specify men who have sex with men or men who are sexually attracted to other men (DeBlaere, Brewster, Sarkees, & Moradi, 2010). Recognizing these complexities, social and psychological researchers have attempted to become more inclusive and aware of language bias against people who are in non-heterosexual relationships or fall outside the gender binary (Brooks & Silverstein, 1995). Terminology for self-identification is also impacted by how a researcher labels other demographic identities (e.g., Hispanic/Latino, Trans men/Transgender Female-to-Male), further complicating studies of racial/ethnic minority gay and transgender men (Huang, Brewster, Moradi, Goodman, Wiseman, & Martin, 2010).

There are also different definitions of coping used across studies, if it is defined at all (Molero, Fuster, Jetten, & Moriano, 2011; Perrig-Chiello & Hutchison, 2010; Twenge, Campbell, & Freeman, 2012), and the term resilience is often even more ambiguous

(Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Burt, Simons, & Gibbons, 2012; Singh & McKleroy, 2010). Given these critiques, it is important to define the terms to be used in the investigation. These terms are noted below.

Activities of daily living – these are hands-on care activities, such as feeding and bathing care recipients (Katz, Downs, Cash, & Grotz, 1970; NAC/AARP, 2009)

Ageism – can include any prejudice or discrimination against or in favor of an age group often involving negative social attitudes towards aging and positive attitudes for youth (North & Fiske, 2012)

Caregiver – the current study explored caregiving, which included assisting another person in activities of daily living, such as getting in and out of bed and instrumental activities of daily living such as providing transportation

Classism – can include any prejudice or discrimination against or in favor of those with different access to economic and political resources, impacting life experiences from birth to death and "mediates and influences what a person is likely to learn, believe, anticipate, and seek after..." (Lott, 2012, p. 650)

Coping – includes adaptive affective and behavioral responses to stressful experiences (Robertson, Zarit, Duncan, Rovine, & Femia, 2007)

Discrimination – includes unfair, unkind, and/or unjust treatment in terms of injustice and inequality of one group of people over another (Williams et al., 1997) and includes distancing, excluding, or denigrating behavior often based on prejudice (Lott, 2012)

Family – for the purpose of this dissertation study, family includes a participant's parent or their partner's parent, a participant's child or their partner's child, and a participant's grandparent or their partner's grandparent. Parent is defined as mother/stepmother and father/stepfather. Children included biological, adoptive, foster, traditional or gestational surrogate, and other parent-child relationships. Grandchildren included the children of participants or participants' partners' sons or daughters including the above mentioned categories of how children are brought into a family.

Gender role conflict – feelings of incongruence between traditional male socialization and current roles, such as caregiving (Mahalik, Locke, Theodore, Cournoyer, & Lloyd, 2001; O'Neil, Helms, Gable, David, & Wrightsman, 1986)

Gender socialization – involves family and cultural modeling and promoting appropriate behaviors aimed at differentiating men and women's social roles; men's socialization is focused on gaining success and power, being competitive, restricting affection toward other men, and putting work ahead of family (Brooks & Silverstein, 1995)

Heteronormative – is the presumption of a heterosexual preference and is the standard of practice in many studies that do not allow for gay, lesbian, or bisexual participants to self-identify as such (Price, 2011)

Heterosexism – an "ideological system that denies, denigrated, and stigmatizes any non-heterosexual..." regarding behavior, identity, and relationships that create exclusionary practices and invisibility (Herek, 1990, p. 317)

Instrumental activities of daily living – these are caregiving activities that are more general assistance provided to care recipients, such as helping with finances, housework, and transportation (Lawton & Brody, 1969; NAC/AARP, 2009)

Intersectionality - a theoretical framework that posits that "multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)..." (Bowleg, 2012, p. 1,267)

Marginalization – is an overview of inclusivity and exclusivity of attitude and behavior in which a minority group is often disempowered and pushed to the side, while the majority group is centralizing power, influence, and resources (Kurtz & Tweed, 2008)

Partner – is an inclusive statement for marriage partner, civil union, or long-term committed relationship involving intimacy and shared resources, which mirrors a marriage or civil union

Prejudice – includes negative attitudes about a group of people including stereotypes, which are widely shared negative beliefs (Lott, 2012)

Racism – can include any prejudice or discrimination against or in favor of one racial/ethnic group over another, including immigrants (Tafira, 2011)

Respite – is a an umbrella term to describe both professionally paid and informal methods of providing caregivers with a break, often used to describe the support provided, but also the desired outcome (Hanson, Tetley, & Clarke, 1999)

Transgender men – transgender identity refers to any person whose gender identity expression may not necessarily be the same gender they were assigned at birth (Hines, 2006). For the purpose of this dissertation, the term transgender men referred to individuals who identify as transgender female-to-male, including those who have undergone hormone treatment, have had any surgery to align a female sexed body with a gender identity of a man, or who self-identify as a man regardless of medical or surgical intervention.

Statement of Purpose

The purpose of the current study was to expand on the knowledge of caregiving roles and psychological distress for caregiving men and the impact of discrimination. Additionally, the study sought to explore access to respite and perceptions of social support for caregiving Baby Boomer men.

CHAPTER II

LITERATURE REVIEW

The purpose of the following literature review was to examine the four major components in the current study: the Baby Boomer cohort, family caregiving roles, men's gender roles and socialization, and discrimination. These fields of research are vast, so the scope of this study was narrowed to Baby Boomer men in caregiving roles to their and their spouse/partner's parents, children, and grandchildren and the impact of ageism, classism, heterosexism, and racism on those caregiving roles. By doing so, decisions were made to exclude studies and findings which did not pertain directly to the defined caregiving roles, including caregiving provided to their spouses/partners, extended family, family of choice, and other forms of informal caregiving. Additionally, the current study is unable to encompass all forms of discrimination and thus excludes certain forms of discrimination, including but not limited to ableism and sizeism.

As there is a large body of research on caregiving, summaries were presented as often as possible to enhance clarity. However, some studies were reviewed in more detail when such a focus was relevant. The literature review was organized by introducing Baby Boomer men as the focus group of the study, followed by describing and delineating their identities as informal family caregivers, discussing the salience of gender roles as they relate to male socialization, and then discussing the impact of various forms of discrimination. At the end of the literature review, a summary is

presented along with the rationale for the current study and its associated research questions.

Baby Boomer Cohort

Baby Boomers (BB), a descriptive term often applied to individuals born between 1946 and1964, make up one of the largest cohorts in history (Maples & Abney, 2006; Schulz & Binstock, 2006). By 2030, one-fifth of the United States (U.S.) population will be over the age of 65 (Laidlaw & Baikie, 2007). In a national survey, the Centers for Disease Control and Prevention (CDC) and the National Association of Chronic Disease Directors (NACDD) (2006) found that adults aged 50 to 65 reported high rates of dissatisfaction in their lives. The CDC and NACDD (2006) survey also found elevated rates of depression and anxiety for BBs.

Role Transitions

Baby Boomers are currently addressing multiple changes in their lives (e.g., Albert, Schulz, & Colombi, 2010; Malone, Beach & Langeland, 2011; Szinovacz, DeViney, & Davey, 2001). BBs may be changing from workers to retirees and from parenting young children to caring for elderly, dependent parents. Others may desire retirement yet continue to work as they become responsible for their grandchildren. While many changes in family roles and responsibilities may be expected throughout the life-span, some changes are unexpected. Change may occur in relationships with significant others and friends as the BB cohort ages and people divorce, move, or die. Concurrently, BBs may also experience changes to their family structure due to aging

parents becoming dependent and the birth of grandchildren. Baby Boomers are seeing

their parents living longer than previous generations and can expect to live longer

themselves (CDC & NACDD, 2006). Baby Boomers may also experience their adult

children remaining in the family home longer than in previous generations (Stenberg-

Nichols & Junk, 1997).

With all these changes, BBs who had previously thought they were done

providing care after their children grew up are finding themselves in caregiving roles

again. Piercy and Chapman (2001) proposed several different influences on how and

why a caregiver role is adopted. Individual family roles can result in different

expectations for caregiving; first born children are often expected to do more caretaking

than their younger siblings. Secondly, caregiver family of origin may have a family rule

that family takes care of family, where caregiving was modeled in the family as what

family members do for one another. Thirdly, religious beliefs or doctrine may dictate

that caregiving is mandatory. A fourth influence is that the behavior itself begets the

identity; individuals who engage in caretaking behaviors may subsequently adopt a

caregiver identity (Piercy & Chapman, 2001).

Similar to cohorts before them, BBs are concerned for their own physical health

in the future and feel uncertain that they will be able to meet their financial needs as they

age with an additional stressor of caring for extended family beyond childrearing

(Malone, Beach & Langeland, 2011). Due to the trend for smaller family sizes (U.S.

Census Bureau, 2008), the burden of caregiving for elderly parents is shared among

fewer children than in previous cohorts; this results in a greater share of the financial

burden of caregiving for individuals in the BB cohort. Thus, more individuals will

continue to report that the financial burden of caregiving is a source of stress (Laidlaw &

Baikie, 2007). In a national survey, nearly 12% of employees were providing elderly

care; these employees also reported higher rates of "depression, diabetes, hypertension, or

pulmonary disease regardless of age, gender, and work type..." than those not providing

care (Albert et al., 2010, p. 5).

Baby Boomers are also at the stage of their lives where considerations for

retirement might include a re-evaluation of family obligations, including caregiving roles

(Szinovacz et al., 2001). Malone, Beach, and Langeland (2011) found that 42% of their

respondents aged 50 to 59 were retired, yet 52% of retirees expecting to continue to work

during their retirement. Retirement decision-making must also be negotiated in intimate

relationships, such as marriage or civil unions, where one or both adults in a family unit

must navigate between paid work and unpaid family responsibility, such as caregiving.

Much of the research on the BB cohort does not define the different experiences

between men and women and does not mention transgender persons unless transgender

issues are the research focus (e.g., Biblarz & Savci, 2010; Clark & Diamond, 2010;

Murphy, 2013). Gender impacts multiple aspects of identity currently facing BBs, such

as work/retirement and caregiving for elderly parents and/or grandchildren (Anastas,

Giveau, & Larson, 1990; Hammer & Neal, 2008). When exploring the psychological

well-being of BB men, gender roles that impact different aspects of men's lives should be

explored, such as negotiating who brings in income and provides family care. In a French study, even though women provided more care, among men who provided care to family members, 90% also worked full-time or 35-hours a week (Bonnet, Cambois, Cases, & Gaymu, 2011). In an U.S. study, men in heterosexual marriages reported "working significantly more hours per week, on average, than [employed] wives (49.5 hours compared to 38 hours)" (Hammer & Neal, 2008, p. 105).

Historically, women have been the primary caregivers and thus have reported more work and caregiving conflict than men (Anastas et al., 1990). However, this historic difference appears to be changing, as more men are now reporting stress from work-life conflict as well (Jang, Zippay, & Park, 2012). The type of care men and women provide has also been shown divide along traditional gender lines, with women providing care services, such as primary caregivers of elderly parents with dementia (Bourgeois, Schulz, & Burgio, 1996), and men providing care services, like financial management and transportation (Piercy & Chapman, 2001). These gender roles in caregiving might be changing as more BBs' parents' age. In MetLife's recent 2010 survey, 61% of the male employed participants reporting caregiving and 48% of these employed caregivers those were aged 50 or older (Albert et al., 2010).

Diversity and Baby Boomer Caregiving

The present study acknowledged that the BB cohort is not a homogeneous group but rather a historically defined population with various societal and within group demographic differences. An example of demographic differences appears to be

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racial/ethnic differences in psychological distress among BB caregivers. Compared to White caregivers, Black caregivers reported "less self-loss [relating to identity] and more self-gain [relating to self-esteem and optimism] in the caregiving role" (Foley, Tung, & Mutran, 2002, p. S19). White caregivers reported higher levels of burden and depression than Black and Mexican American caregivers (Connell & Gibson, 1997). Mintzer et al. (1992) speculated that within-group variation also might impact the caregiving experience because they found no difference in level of depression between White and Cuban American caregivers. In another study that did not find racial/ethnic differences, both Black and White female caregivers who experience a great deal of role conflict between work and caregiving responsibilities also reported a loss of self or identity (Foley et al., 2002).

Another demographic factor influencing the caregiving roles of BBs is sexual orientation. There are between 4-8 million lesbian, gay, bisexual, and transgender BBs in the U.S. (Grant, Koskovich, Frazer, & Bjerk, 2009). In 1999, 32% of BB gay men and lesbian women were providing some type of informal care (Fredriksen, 1999). A similar study in 2006 found 25% of BB gay, lesbian, bisexual, and transgender adults were providing informal care (Haefele, 2010). The national average in the U.S. for caregiving BBs is 21% (Haefele, 2010), so lesbian, bisexual, gay, and transpersons are providing higher levels of informal caregiving than are their heterosexual and non-transgender counterparts.

Summary of the Baby Boomer Cohort

Baby Boomer men face a number of choices and role conflicts as they age in the domains of work and caregiving. The size and heterogeneity of the BB cohort does not allow for broad generalizations. However, the U.S. BB cohort as a whole can be expected to experience a predictable set of choices and conflicts related to their current age. Some of these choices and conflicts may include managing financial resources, negotiating caregiving of family members, and coping with stress from demographic differences such as race/ethnicity, income, and aging (e.g., Black et al., 2010; Finkelstein, Reid, Kleppinger, Pillemer, & Robinson, 2012; Haefele, 2010; Longino, Jr., 2005; Maples & Abney, 2006). U.S. BB men are no longer young men. Many BB men find themselves in the position of having to add caregiving to the roles they already balance. The added caregiver role creates additional dynamics and complexities in their lives. For minority and marginalized BB men, the addition of this role may be even more complex as it intersects with other identity variables and discrimination experiences. These dynamics were explored in more detail in the following sections.

Family and Intergenerational Caregiving

The current study examined specific aspects of family caregiving. Comparing different studies on family and the role of caregiving can be challenging as the definition of family varied across studies. The Administration on Aging (2010) grouped grandparents, adult family members, and other relatives into their definition of informal family caregivers. For Biblarz and Savci (2010), family was defined as two adults in a

relationship and their children. Clark and Diamond (2010) recruited informal caregivers and defined family after they gained their sample. They found caregivers among many relatives and defined family in their study as spouses, sons and daughters, and other family members who included grandchildren, nephews, nieces, brothers, and sisters.

The definition of family varied across research designs and social contexts. Much of the research presented in the current literature review, unless otherwise specified, utilized nuclear, heterosexual family units. These families were often composed of only parents and their young children. The gender roles of these families were often traditional, including fathers as the primary breadwinners and mothers as the primary caregivers. This research has limited the applicability of the existing research to modern U.S. society, which has grown to include a broader array of family configurations and family roles.

The current researcher wanted to capture more contemporary family units by acknowledging the diversity of family compositions that may include blended families, families with flexible gender roles, families with same gendered partners, and/or multigenerational families. At the same time, to anchor the research sample, the current study defined care recipient in the following section on elderly parents, children, and grandchildren. The current researcher also acknowledges the role and importance of extended family or kinship networks (Haefele, 2010) and family of choice (Muraco, LeBlanc, & Russell, 2008).

Just as families are diverse, BB men are also not a homogeneous group. While BB men have different kinds of families, the median BB man is married or in a committed relationship, has one or both parents still living, has children, and has a strong desire to remain socially active (Malone Beach & Langeland, 2011). The context of a typical BB man may include multigenerational interpersonal systems and could include multiple caregiving and care recipient roles. The multiple caregiving roles implied by having both children and aging parents, in addition to work or transitioning to retirement, may stress BB's financial resources and time resources, as well as their relationship commitments. For example, when caregivers provide "more caregiving tasks than usual or are faced with more care recipient behavior problems (e.g., anger/aggression, being awakened at night), they experience an increased level of depressive symptoms, feelings of burden..." and increased negative physical health symptoms (Koerner & Kenyon, 2007, p. 8). The psychological distress of BB men providing caregiving is impacted by multiple factors and roles in their lives.

Caregivers and Caregiving Targets

Baby Boomers are providing a substantial amount of informal caregiving (Administration on Aging, 2010; Haefele, 2010; NAC/AARP, 2009). Most of these caregivers had family incomes less than $50,000 as families, with higher incomes reported higher rates of paid care support (NAC/AARP, 2009). Family caregivers provided, on average, 20 hours a week for about 4.6 years of informal care to family members (NAC/AARP, 2009). Extended caregiving negatively impacts caregivers'

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physical and mental health; caregivers providing care for five or more years and/or

providing 21 or more hours of care a week are twice as likely as short-term caregivers to

report health decline and psychological distress (NAC/AARP, 2009). The face of

informal caregiving is also changing, as more men are providing up to 34% of all

informal family care (NAC/AARP, 2009). Caregiving men supply more instrumental

activities of daily living (IADL) than women, and those who provide more than eight

hours of care a week supply nearly 25% more IADL per week than those who provide

few hours (NAC/AARP, 2009).

Baby Boomers are providing many types of family caregiving. Research on

caregiving that does include men participants has caregiving men providing more

administrative or hands-off roles (i.e., IADL) compared to caregiving women who

provide more intimate or hands-on assistance (del-Pino-Casado et al, 2010; Haefele,

2010). The Family Caregiver Alliance (2010) found approximately 43.5 million of all

BBs are providing some type of care for their aging parents. Baby Boomers are also

supporting and providing care to younger family members. Over half of adult children

over the age of 18 are still living with their parents (U.S. Census Bureau, 2011a).

Grandparents caring for grandchildren make up nearly 12 % of family caregivers

(Administration on Aging, 2010). Most of the current research on caregiving BB men

focuses on spousal care and often excludes unmarried partnership arrangements (Baker,

Roberston, & Connelly, 2010; Conde-Sala, 2009; del-Pino-Casado, Frías-Osuna,

Palomino-Moral, & Martínez-Riera, 2012). While spousal care has been shown to be a

concern for BB men, the current study focused on the less studied phenomenon of BB

men who engage in intergenerational or multigenerational family caregiving. The

following section will explore how BBs are often caring for multiple generations of

family members.

Baby Boomers and their aging parents. The U.S. population is aging and more

elderly people need assistance in their daily lives than ever before (Administration on

Aging, 2010). For example:

> The proportion of caregivers of adults who provide help with at least one
>
> activity of daily living increased from 50% in 2004 to 58% in 2009... 2009
>
> saw an increase in the proportion of caregivers of adults who help their
>
> loved one with housework (75%, up from 69% in 2004), preparing meals
>
> (65%, up from 59%), and arranging or supervising outside services (34%,
>
> up from 30%). (NAC/AARP, 2009, pp. 23-24)

Family members play a greater role in caregiving for older adults than the spouses of

those older adults (Family Caregiver Alliance, 2010). Specifically, the caregivers of

older adults are usually their adult children (Family Caregiver Alliance, 2010), with one

in 12 caregivers providing care to a parent-in-law or a grandchild of a spouse/partner

(NAC/AARP, 2009). Some researchers use the term sandwich generation to explain the

complicated position some caregivers find themselves in as adult children having to

simultaneously care for their aging parents while also raising their young children

(Hammer & Neal, 2008; Miller, 1981). However, it is often difficult to research the

sandwich generation because definitions vary as to what ages of parents, ages of children, and types of care qualify individuals as belonging to the sandwich generation (Hammer & Neal, 2008).

When asked why older family members need care, the two most common reasons given are old age (12%) and Alzheimer's or dementia (10%) (NAC/AARP, 2009). Other frequently mentioned reasons are mental/emotional illness (7%), cancer (7%), heart disease (5%), and stroke (5%) (NAC/AARP, 2009). The majority of the research currently available on elderly care pertains to Alzheimer's disease and dementia; the caregivers in these studies are usually identified as women (Holland et al., 2010; Mitrani, Lewis, Feaster, Czaja, Eisdorfer, Schulz, & Szapocznik, 2006; Robertson et al., 2007). Baby Boomers who provide care to adults with Alzheimer's disease or advanced dementia report negative emotional effects, including depression, stress, and fatigue, financial stress, and work-life conflicts, which result in such outcomes as having to refuse promotions or take early retirement in order to fulfill their caretaking obligations (Black et al., 2010; Bonnet et al., 2011). Caregiving for individuals with dementia can lead to prolonged depression (O'Rourke, Cappeliez, & Neufeld, 2007). Prolonged depression in dementia caregivers has also been shown to lead to poor physical health of caregivers (O'Rourke et al., 2007). The previously mentioned research reported limited sample sizes of men and/or a research focus on women, so little is known about BB men's experiences as caregivers for their parents with dementia. For example, the proportion of men in the studies noted above ranged from 20% (Robertson et al., 2007) to 44% (Black

et al., 2010), and most fell in the 24-28% range (Bonnet et al., 2011; Foley et al., 2002; Mitrani et al., 2006).

BB caregivers of elderly parents face unique stressors different from those experienced in other forms of informal family caregiving. Older BBs caring for their parents may have to confront their own fear of aging, especially when their parents suffer from conditions with hereditary components, such as Alzheimer's disease, diabetes, or heart disease (Terry, 2008). Providing care to aging parents may cause additional psychological stressors, such as role reversal, when parents become dependent or anticipatory grief around terminal illness and progressive dementia (Terry, 2008). Providers of elderly parent care also report high levels of helplessness as their parents' health and cognitive function deteriorate (Terry, 2008). While most research stresses the struggles of dementia caregivers, these caregivers can also report high levels of resilience through self-efficacy, problem solving, and positive role perception of providing care (Holland et al., 2010).

Baby Boomers and their children. Young adults are living with their parents for longer periods of time than in previous generations (Mitchell, Wister, & Gee, 2004; U.S. Census Bureau, 2011a). Additionally, more young adults are returning to live in their parents' homes after college or due to financial struggles. Young adults from all socio-economic status levels (SES) are remaining in school longer and are marrying and starting their own families later in life than in previous generations (Furstenberg Jr., 2010). More young adults are residing with their parents; a recent study in 2009

indicated that this may include as many of 59% of sons and 50% of daughters aged 18 to 24, an increase from 53% and 46% respectively in 2005 (U.S. Census Bureau, 2011a). Similarly, men age 25-34 living in the homes of their parents rose from 14% in 2005 to 19% in 2011; the percentage of women increased from 8% to 10% during the same time (U.S. Census Bureau, 2011a). Limited research has explored the caregiving role of BB parents providing support to their healthy adult children. Raphael and Schlesinger (1993) studied women between the ages of 40 and 60 who were primary caregivers sandwiched between their young adult children still living at home and the caregivers' parents. The researchers found that elderly parents' health and family SES mediated caregiver interpersonal interactions with their parents. The mediating effect of care recipient need and income is unknown for BB men due to a dearth in research for caregiving men.

Limited research was available on the parental experience of gay, bisexual, or transgender (GBT) fathers. For example, more research has been done for lesbian mothers than for gay fathers or "family structures, processes, and relationship that include bisexual or more sexually [and gender] fluid parents and their children..." which have hardly been explored (Biblarz & Savci, 2010, p. 493). Historically, most GBT men who were fathers became fathers during a previous heterosexual relationship or through sperm donation (Dempsey, 2010). The past few decades have allowed BB GBT men more opportunities for fatherhood than in previous generations, due to advances in reproductive technologies, legislative changes in adoption laws, or surrogacy arrangements (Biblarz &Savci, 2010; Dempsey, 2010). Recent research indicates a

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substantial subset of gay men are interested in fatherhood (Goldberg, Downing, & Moyer, 2012; Riskind & Patterson, 2010). Additionally, GBT men and GBT fatherhood choices are becoming increasingly visible in the media, which allows multiple generations of GBT men to conceptualize themselves as fathers (Murphy, 2013) and grandfathers.

Although some GBT men are fathers or provide care for children, it is more common for GBT men to be childless and have few or no childcare responsibilities. While heterosexual adults are more likely to desire parenthood than gay or lesbian adults, parenthood is equally valued among adults regardless of sexual orientation (Riskind & Patterson, 2010). Riskind and Patterson (2010) found 30% of gay men have a desire to be parents yet are less likely than heterosexual men to plan on becoming fathers. In a national survey of gay and lesbian BBs in their late 30s, only 7% were providing care to a child 17 years of age or younger and a majority of these parents and caregivers were lesbian women (Fredriksen, 1999). GBT fathers may also experience increased feeling of isolation from local GBT community because of their parental status and may find more comfort from and connection with heterosexual parents than with childless GBTs (Oswald & Culton, 2003). Gay men who decide to become fathers do so in direct confrontation of a heteronormative society's expectation of who are parents and what parenting should look like, as in mothers and fathers (Goldberg et al., 2012). Gay fathers therefore are in social positions to address parenthood from not only a normalized adult transition but also from the social context of a political statement (Goldberg et al., 2012).

There has been limited research into the experience of transgender parents, with the exception of the previous mentioned study by Biblarz and Savci (2010). Transgender men, such as Thomas Beatie (2008), are just now beginning to speak out on the difficulties facing transgender men who decide to gestate their own children, such as negotiating the medical community and dealing with social discrimination and harassment.

Baby Boomer grandparents caring for grandchildren. As is consistent with other caregiving research, the majority of grandparent studies have focused on grandmothers. The following section will specify when grandfathers were differentiated in the research. The majority of available research indicates that BBs are currently the largest cohort with grandchildren (Administration on Aging, 2010; U.S. Bureau of the Census, 2011b). The role of grandparent (GP) can be very rewarding, especially when GPs see their children often (Reitzes & Mutran, 2004). Many GPs not only visit and/or help with grandchildren, but also are living with and caring for grandchildren. The number of GPs providing coresident care to grandchildren has jumped from 5.8 million in 1999 (Simmons, Dye, & Bureau of the Census, 2003) to 6.7 million in 2009, with 2.7 million of those being the primary caregiver for one or more grandchild (U.S. Bureau of the Census, 2011b). Of GP households caring for grandchildren, 34 % do not have the grandchildren's parents in the household (Simmons et al., 2003). About 70% of GPs provide care for longer than two years (Luo, LaPierre, Hughes, & Waite, 2012). Some of the reasons for GPs raising grandchildren include parental drug or alcohol use, parental

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imprisonment, unemployment or underemployment of parents, parental mental illness, parent divorce, death of parents, lack of alternative caregivers, child safety concerns, and/or abandonment (Burnette, 1999; King et al. 2009; Letiecq et al., 2008).

There are also large racial/ethnic differences in who is providing care to grandchildren. Only 2% of White GPs are coresident with grandchildren compared to 6% of Asian GPs, 8% each of Native American, Black, and Hispanic GPs, and 10% Pacific Islander GPs (Simmons et al., 2003). Over half of the Native American and Black GPs were primary caregivers to the grandchildren living with them, a situation which applied to only 20% of Asian, 35% of Hispanic/Latino, 39% of Native Hawaiian/Other Pacific Islander, and 42% of White grandparents (Simmons et al, 2003). In 1999, of multigenerational households, 36% consisted of grandfathers' coresident with grandchildren (Simmons et al., 2003). Some of the most recent estimates of grandfathers who live with grandchildren project that 43% of these grandfathers are responsible for their grandchildren (U.S. Bureau of the Census, 2012).

Grandchild caregiving may also result in enormous financial strain on GP-headed households. In 1999, 19% of GP caregivers lived below poverty level with some states having rates as high as 30% (Simmons et al., 2003). Recent statistics report that poverty rates for GP raising grandchildren have fallen to 8% (U.S. Bureau of the Census, 2011b). Economic resources can vary not only regionally but also between racial/ethnic groups. In a national survey of Black BB grandparents raising grandchildren, Minkler and Fuller-Thompson (2000) found that the poorest participants provided the most care. In an

attempt to explore Hispanic GPs, Burnette (1999) recruited mostly BB grandmothers

from the New York City area. Participants were mostly Spanish-speaking grandmothers

at or below poverty level and unable to work due to transportation and child care

limitations. The participants with the least education reported having to drop out of

school to be family caregivers (Burnette, 1999). These two studies provide clear

examples of the impact of multiple marginalized identities on a household.

When possible, GPs raising grandchildren are continuing to participate in the

labor force (U.S. Bureau of the Census, 2011c). Letiecq's et al. (2008) small sample of

White and Native American GPs found that, even though 40% worked, most of that work

was part-time. In addition to the low income levels found in the households of many GP

raising grandchildren, federal and state welfare programs also provide little to no support

for grandparents raising grandchildren (Copen, 2006).

Being a custodial GP can cause a great deal of psychological distress (Crewe,

2006; King et al., 2009; Letiecq et al., 2008). GPs raising grandchildren without parental

support reported lower self-esteem, more role strain, including financial struggles, and

less satisfaction with family life and friends than non-caregiver grandparents (Hayslip et

al., 2002; Westaway, Olorunju, & Rai, 2007). Custodial GPs report concerns about their

grandchildren's health and their own health in addition to feeling isolated and

marginalized (King et al., 2009). Hispanic grandmothers raising grandchildren reported

that support groups were extremely beneficial by providing information, normalizing and

validating their experiences, and also providing respite from their grandchildren with other adults who understand their situation (Crewe, 2007).

Researchers attempting to determine the best predictors of depression for GPs raising grandchildren found stress, large time commitments providing care, low income, and being a minority were the most critical variables (Letiecq et al., 2008). Crewe (2006) found differences in depression between ages of GPs. GPs over the age of 63 reported focusing more on the positive aspects of being primary caregivers to grandchildren, while those younger reported higher rates of burden and stress (Crewe, 2006). GPs in grandchild caregiving roles also reported high rates of loss and grief. These GPs reported "loss of freedom, disappointment and anger [in some cases] with their children and lack social support" (Crewe, 2006, p. 205). For GPs raising grandchildren in the southern part of the U.S., HIV and AIDS have placed an increasing burden on older Black BBs (Westaway et al., 2007). These GPs face disproportionately higher rates of unemployment than White GPs and have limited access to financial and community resources to counter the social, psychological, and economic impact of the loss of friends and children leaving grandchildren parentless (Westaway et al., 2007).

The Impact of AIDS

As previously mention on the formation of grandparent caregiving roles, AIDS has impacted families and contributed to the creation of multigenerational households (Crewe, 2006; Westaway et al., 2007). The introduction of HIV/AIDS in the U.S. also has had other impacts. Herek and Capitanio (1998) showed that negative attitudes toward

people with HIV are based more on religious and political values than on concerns for personal safety. Those with HIV were marginalized to the point that willing caregivers were scarce; creating a caregiving shortage in which gay and lesbians provided the majority of informal care (Turner, Catania, & Gagnon, 1994). Informal care to people living with HIV/AIDS continues to be provided by a mix of family and non-family members, with almost half of informal care being provided by family members (Mitchell & Knowlton, 2009). More recent studies showed stigma for caregiving to recipients with HIV/AIDS continues (Bogart, Cowgill, Kennedy, Ryan, Murphy, Elijah, & Schuster, 2008), in spite of the knowledge that social support and openness about the caregiving role decreased psychological distress from stigma for caregivers (Mitchell & Knowlton, 2009).

The role of caregiver became an identity for many gay and lesbian adults, with a broad range of care recipients, including partners, friends, and neighbors (Fredriksen, 1999; Shippy et al., 2004). When caregiving tasks and care recipients were examined in gay men and lesbian women (Fredriksen, 1999), gender differences in caregiving behavior still appeared. Gay men provided more IADL care to other adults, while lesbian women provided care to those that needed more activities of daily living (ADL) help, such as the elderly and children. In a more recent study, men continued to appear to be the primary informal caregivers of those who have AIDS, 54% (Darling, Olmstead, & Tiggleman, 2010).

Coping with Family Caregiving

BB men who provide care show differences in resilience amongst themselves (Laidlaw & Baikie, 2007), yet researchers still do not fully understand why some caregivers exhibit more adaptive affective responses to the stressful experiences of caregiving than others (Robertson et al., 2007). Some racial, age, and role differences have been found to be important variables in caregiver psychological well-being. Being a younger Black caregiver of either gender was associated with positive psychological effects, including growth in self-efficacy, competence, and well-being (Connell & Gibson, 1997; Foley et al., 2002; Jordan-Zachery, 2009). However, for White caregivers, positive psychological effects are found only for older female caregivers (Foley et al., 2002). The relationship with the care recipient also impacts caregivers' well-being. Both men and women caregivers can and do experience positive emotional growth through the relational experience of caregiving, even when caring for older family members with dementia (Robertson et al., 2007).

The positive emotional experience of caregiving might be related to the BB cohort's desire to be of service and socially active. BBs ascribe a greater importance to the intrinsic values of self-acceptance and community engagement than do members of younger cohorts (Twenge et al., 2012). BBs appear to have a strong desire to increase their civil engagement when they retire; this civil engagement may take the form of volunteering, charitable donations, and/or being social, political, and/or environmental advocates (Malone Beach & Langeland, 2011; Twenge et al., 2012). The need to be of

service may result in a greater likelihood of, or willingness to, engage in caretaker roles for BBs. For example, the social gains of being a GP caregiver can depend on the GP's perspective of the caregiving role, such as having a sense of purpose and being valued (Thiele & Whelan, 2008).

Caregiving BB's may experience particularly high levels of distress. Multiple stressors include BB's own aging, aging parents, adult children needing assistance, including care with the BB's grandchildren, and economic considerations, including costs of being a caregiver, and employment options, including retirement or part-time work. These multiple factors impact the ability to manage, minimize, and recover from psychological distress. The ability to cope successfully during periods of life transitions and responsibilities increases with good health, including subjective health and low levels of stress, such as freedom from "chronic anxiety, social isolation, problems with immediate family" (Perrig-Chiello & Hutchison, 2010, p. 204).

A successful coping strategy is to have positive, close relationships with others, and knowing when and how to ask for help, which increases competencies, self-efficacy, and coping (Perrig-Chiello & Hutchison, 2010; Steffen, McKibbin, Zeiss, Gallagher-Thompson, & Bandura, 2002). Social support comes in many forms and may be provided in the familial living arrangement, such as those found in multigenerational caregiving households. For example, some research has suggested that having adult children living in the same household might ease eldercare burden for women (Burnette, 1999; Raphael & Schlesinger, 1993). The social support of marriage also has been

shown to have a beneficial impact on individual health, although it appears to have a stronger benefit for Black and Hispanic individuals than for White individuals (Pienta, Hayward, & Jenkins, 2000). GP caregivers, who have other adult children available to assist in caregiving or provide respite from caregiving, report fewer depressive symptoms than those with limited or no support (Letiecq et al., 2008). The use of respite or social support to assist in providing temporary relief from caregiving is utilized more by those providing more intensive caregiving situations, such as more hours a week and/or more assistance with activities of daily living (NAC/AARP, 2009).

The caregiving role for BB men is connected to multiple contexts, which may impact their ability to access resources, such as support and to manage multiple stressors. For example, in their meta-analysis of existing literature examining coping and different types of BB unemployment, McKee-Ryan et al. (2005) found different correlates for well-being, which can impact BB's caregiving roles. The authors referred to well-being as psychological and physical health, and life satisfaction. One element contributing to psychological and physical well-being is having adequate coping resources, such as personal resilience, social support, financial resources, and flexible time structure. Another element contributing to well-being is cognitive appraisal, which includes the ability to have insight into the need for a respite from caregiving and to understand when high levels of stress and/or practicing inadequate coping skills are experienced. A third factor affecting well-being is possession of a coping strategy that is solution and problem

focused. McKee-Ryan et al. (2005) also acknowledged demographic barriers to well-being, such as discrimination, low SES, and managing work identity when not working.

Caregiving can have some positive benefits rather than just negative consequences. The degree to which caregivers experience competency, creativity, and confidence in care is vital in their ability to experience the positive benefits of caregiving, such as feelings of role enrichment and satisfaction, reduction of uncertainty, enhancement of coping, and creating a sense of meaning associated with providing care (Cartwright, Archbold, Stewart, & Limandri, 1994; Roberto & Jarrott, 2008). For example, Robertson et al.'s (2007) study on caregiver affect found well-adjusted caregivers demonstrated positive affect, including low levels of stress and high reported well-being, and had a number of shared characteristics. The Robertson et al. (2007) study found that positive adjustment to the caregiver role was associated with being male, having high levels of education, and being in good health.

Caregiving men appear to report higher life satisfaction than caregiving women. However, it is also possible that some of the gender differences in life satisfaction related to caregiving roles may be the result of underreporting adverse impacts of caregiving by male caregivers in addition to men's higher report of hiring professional caregiving help (del-Pino-Casado et al., 2012; Mitrani et al., 2006; Perrig-Chiello & Hutchison, 2010). Well-adjusted caregivers also reported lower levels of feeling that they were held captive by their caregiving role and reported both the highest subjective experience of caregiving competence and the lowest levels of role overload (Robertson et al., 2007). The care

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recipients for well-adjusted caregivers had fewer needs related to activities of daily living, such as needing help bathing, and the least amount of disruptive or negative behaviors, such as wandering at night and disrupting others' sleep (Robertson et al., 2007).

Few studies have addressed racial or ethnic differences in caregivers. In Holland et al.'s (2010) study on stress levels with Chinese American caregiving women, strong ethnic and traditional cultural beliefs appear to have buffered the stress and anxiety of caregiving. Mitrani et al. (2006) found that healthy family functioning, including open communication, decreased feelings of burden and/or emotional distress for both White and Cuban American dementia caregivers. However, type of caregiver-care recipient relationship did not appear to be linked to caregiver stress. Thus, high income caregivers and low income caregivers did not report significant differences in their experiences of caregiver stress; similarly, there were no significant differences in caregiver stress between caregivers providing care for spouses versus those providing care for parents or children. Social support from non-family members is also beneficial to caregivers. Membership in a religion and having a close faith community reduces psychological distress and can provide both physical and psychological respite (Burnette, 1999).

Summary of Baby Boomer's Family Caregiving

Being an informal family caregiver is a complicated intersection of family roles, finances, time, and other resources. Many BB men may find themselves providing care to family members in various situations. These situations may include multigenerational

caregiving roles that may not follow traditional definitions of sandwich generation

responsibility but may include various configurations of caregiving for their parents,

adult children, and/or grandchildren. While most research focuses on the negative impact

of caregiving on caregivers financial and psychological resources, BB men with a

positive perspective on their caregiver role and close relationships with others may

benefit from caring for others.

Gender Roles

There is a dearth of research on men's experiences in caregiver roles (Doucet,

2006). Social expectations in the U.S. have historically placed men in the roles of being

the primary earners for a nuclear family and women in the roles of primary caregivers in

those families (Fox, 2001). Women have a life course trajectory of caregiving supported

by socio-cultural norms that men do not have (Hooyman, Brown, Ray, & Richardson,

2002). Men who have to take on caregiving roles are confronted by what independence,

vulnerability (both physical and emotional), and strength may mean (Mahalik et al.,

2001). BB men may be vulnerable to the belief that they are only valuable and attractive

to others if they appear to be more like younger, heterosexual men (Calasanti, 2004). "To

be placed in a position of primary caregiver [other than working] ...signals something out

of sync with what many communities consider as a socially acceptable 'moral' identity

for a male" (Doucet, 2006, p. 707). The conflict of identity and role can impact men in

multiple ways. The following discussion will explore examples of socialization and

gender role conflict.

In the U.S., traditional male socialization stems from a patriarchal history and includes the promotion of behaviors aimed at gaining success and power, being competitive, restricting affection toward other men, and putting work ahead of family (Brooks & Silverstein, 1995). Enactment of these behaviors has been shown to result in psychological distress for men as they attempt to achieve these standards and/or when conflict and confusion arise regarding the differences between their actual behaviors and the expectations ascribed to their male role (Brooks & Silverstein, 1995). Men are often uncertain about how to balance what they see as being masculine with the behaviors their current situation requires, and may feel ashamed when they find themselves falling short of achieving this balance (O'Neil, Helms, Gable, David, & Wrightsman, 1986). Feelings of incongruence between traditional male socialization and current roles, such as caregiving, are often referred to as gender role conflict (GRC; Mahalik et al., 2001; O'Neil et al., 1986).

Baby Boomer men's roles within a family have changed dramatically in the past few decades. Traditional gendered behaviors become less appropriate as men take on more caregiving responsibilities. Men are now expected to contribute more to interpersonal family relationships than in previous eras (e.g., Baker et al., 2010; Family Caregiver Alliance, 2010). For BB men, GRC may occur when men suddenly take on caregiving roles which may conflict with their template or assumptions about gender roles. Gender role conflict can impact multiple areas in caregiving BB men's lives, such as interpersonal, career, and family domains (O'Neil, 2008). Caregiving and nurturing

maybe sacrificed while attempting to meet obsessions of success and/or achievement. Interpersonal relationships and communications are hampered by restricted affect and/or a focus on power, control, and competition. Men who experience GRC may also have more personal health problems and increased homophobia relating to a fear of appearing feminine (O'Neil, 2008).

Baby Boomer men with higher levels of GRC expressed lower self-esteem and greater difficulty with intimacy, such as emotional self-disclosure and comfort with others' emotional expressiveness (Mahalik et al., 2001; O'Neil, 2008). The difficulty with developing and sustaining intimacy can greatly impact a BB man's ability to manage stress, especially when placed in the role of family caregiver (Mahalik et al., 2001). There is evidence that traditional caregiving gender roles may be changing, allowing men to conceptualize themselves in caregiving roles and alleviating GRC. Hammer and Neal (2008) found that married heterosexual men who work full-time were providing eight hours of a week of elder parental care, while their wives were providing ten hours a week. The increasing availability of other men modeling flexibility in caregiving may pave the way for a cultural shift in gender roles around caregiving.

Few studies have examined aging and masculinity (Calasanti, 2004) and even fewer have examined how aging and masculinity intersect with caregiving (Hooyman et al., 2002). This researcher was unable to find research exploring how these aspects of role and identity might be impacted by discrimination. The dominant Western concept of masculinity is synonymous with the physical strength of youth, a good job and income,

independence, and the use of logic over emotion (Calasanti, 2004). Aging challenges

many of these cultural norms for White, middle to upper class, heterosexual men and can

present additional challenges for the identities of marginalized men.

Race/ethnicity and sexual orientation also intersect with caregiving and gender

roles. Gender is a social construct that comes from an interaction of environmental

factors, such as family and peer values and roles, and biological factors, such as sex and

race/ethnicity (O'Neil, 2008). Men facing discrimination may experience conflict with

their gender role and/or their own masculinity based on these factors (O'Neil, 2008). The

experience of GRC, according to O'Neil (2008), includes the negative outcomes of

adhering to or deviating from culturally defined masculinity, which can vary among

different groups of men. An example of the variation between men is the lower reports

of GRC in older gay men than in heterosexual men (O'Neil, 2008).

The intersection of race/ethnicity and GRC may explain differences in caregiving

done by men. "Half of Asian-American caregivers are male (50%), whereas the

proportion of caregivers who are male is smaller among Hispanics (34%), African-

Americans (30%), and Whites (34%)" (NAC/AARP, 2009, p. 15). Asian American men

include a culturally diverse population whose GRC is strongly correlated with

acculturation process in the U.S. (O'Neil, 2008). The pressure to conform to White

gender roles stressed by Western society may place many Black men at risk for

experiencing high rates of GRC (O'Neil, 2008). Latino men are also at increased risk of

GRC, if they strive to adhere to stereotypical machismo or hyper-masculine gender roles

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(O'Neil, 2008). The following section will elaborate on the complexity of multiple

identities and family roles.

Intersection of Multiple Roles

Baby Boomer men who become caregivers may often find themselves with

multiple role conflicts, including conflicts between multigenerational caregiving, work,

retirement, and/or self-care planning (Miller, 1981). Although both men and women

provide various kinds of support to family members, women usually engage in caregiving

for longer amounts of time each week and provide more personal assistance with

activities of daily living (ADL), such as feeding and bathing, than do men (del-Pino-

Casado et al., 2012). Conversely, the care men are more likely to provide typically falls

under the category of instrumental activities of care (IADL), such as financial support or

planning and transportation (Hequembourg & Brallier, 2005; MetLife, 2006; Paoletti,

2002). Even when men are not primary caregivers, they often serve in various support

roles to the primary caregiver, usually a woman (Stephens, Townsend, Martire, &

Druley, 2001).

Even though research is limited on the experience of caregiving BB men, studies

show that they are not a homogeneous group. Foley et al. (2002) found that men with

low levels of education and income preferred that caregiving be done by female family

members rather than paying for professional caregiving. Although men have begun to

provide more care than they did in the past, in the present era women still provide

approximately 75% of long-term family care (Family Caregiver Alliance, 2010; Laidlaw

& Baikie, 2007; Manton, 2010; Robertson et al., 2007). Traditional gender roles around caregiving are starting to change as men report taking on caregiving roles that include children and elderly at higher rates than previous generation's men who provided care mostly to spouses (Haefele, 2010; U.S. Bureau of the Census, 2012).

Men's Relationships

Individual relationships may include a range of interpersonal connections, including those with spouses/partners, extended family, friends, and various cultural communities, such as faith communities, or communities united around shared demographics, such as race/ethnicity and sexual orientation. These relationships are dynamic and may come and go in individuals, such relationships can be sources of both support and conflict (Burnette, 1999; Graham & Barnow, 2013), including GRC, as men may struggle to show emotion and affection especially to other men (O'Neil, 2008).

While group-level data on changing male roles show some degree of responsive flexibility, individual attitudes appear to be less flexible (Brooks-Harris, Heesacker, & Meijia-Millan, 1996). Shame, which is a major component of GRC (O'Neil et al., 1986), is related to psychological distress and more negative affective responses to caregiving for men (Funk & Werhun, 2011; O'Neil, 2008; Thompkins & Rando, 2003). Just as social support is a positive coping strategy for family caregivers, research has also shown that positive social support can decrease shame and improve depressive symptoms for men reporting high GRC (Szymanski & Ikizler, 2013; Wester, Christianson, Vogel,

&Wei, 2007). Social support, including positive family relationships and open communication, can reduce caregiver stress and burden (Mitrani et al., 2006).

Limited research is available examining the impact of social support on minority caregivers. One study found social support, such as support from close family, friends, and members of a faith community, are significantly positively associated with higher self-rated happiness and life satisfaction scores for healthy, older, married, Black men and women above poverty level (Taylor, Chatters, Hardison, & Riley, 2001). Older Hispanic women caregivers reported that social support was very beneficial to their psychological well-being and their ability to provide care, especially when they were able to get occasional respite from their primary caregiver roles (Crewe, 2007).

Another important aspect of social support for psychological health is related to individuals' spouse or committed partner. BB men are both positively and negatively impacted by the changing face of intimate relationships in the U.S., including continued high rates of divorce (Maples, & Abney, 2006) and changing legislation related to same-sex marriage (Chamie & Mirkin, 2011; Hatzenbuehler, O'Cleirigh, Grasso, Mayer, Safren, & Bradford, 2012). Most research that discusses caregiving men involves spousal care (Adams et al., 2002; Baker et al., 2010; Jang et al., 2012) or men who support their primary caregiving wives (Anastas et al., 1990; Black et al., 2010). Having positive marriage relationships decreases depressive symptoms and increases life satisfaction for both men and women (Antonucci, Lansford, & Akiyama, 2001). Relationship satisfaction and interpersonal support are not guaranteed even when

individuals are married or in a relationship. Divorce also has a serious negative impact on affect, although it appears to have differential impact amongst different racial/ethnic groups; Hispanic individuals report higher psychological stress and poorer physical health after a divorce than Black or White divorcees (Pienta et al., 2000).

Having multiple types of relationships can provide different psychological benefits. For White men, conflict in casual friendship relationships appears unrelated to depression, but conflict with their best friends is linked to a decrease in self-reported life satisfaction (Antonucci et al., 2001). When today's BBs were in their late 30s, cohabitating gay men would often name friends before partners as their primary sources of social support (Kurdek, 1988). A more contemporary study found the opposite to be true with older BB gay men, who are more likely to name partners as their primary social support (Shippy et al., 2004). In an even more recent study, social support from friends and family improved well-being, with partner support buffering individuals from stress regardless of sexual orientation (Graham & Barnow, 2013). Women reported higher rates of seeking social support during times of distress than men and often form caregiving networks to maximize resources (Taylor, Klein, Lewis, Gruenewald, Gurung, & Updegraff, 2000). In contrast, BB men reported rarely or never receiving the social support they need (CDC & NACDD, 2006).

Life transitions, including aging and changes in interpersonal responsibilities, can negatively impact long-standing relationships and partnerships (Levy, 2003). Marital partners who are not in agreement about continuing to work versus moving towards

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retirement may find that these differences impact both affect and relationship quality. Full retirement for both partners often equates to experiencing overall improvement in well-being and positive feelings within the relationship, whereas the transition process between work and retirement often adversely impacts both partners; men reported lower marital satisfaction and higher conflict during this transition than women (Moen, Kim, & Hofmeister, 2001). These changes in the life-course can become more complicated in marginalized populations. Some of these role transitions can be felt as extreme by one or both partners and lead to a dissolution of the relationship or rejection by the family (Hines, 2006).

Unique Issues for Gay and Transgender Men

The meaning of masculinity is a social construction which includes gender roles and expectations (O'Neil et al., 1986). For example, masculinity expectations in the U.S. have historically devalued or delegitimized same-sex relationships, which may explain why gay men's psychological distress often increases when GRC intersected with heterosexism and work-family responsibilities (Szymanski & Ikizler, 2013).

Being a part of a common community can provide resources and support from GBT men. However, disclosing marginalized aspects of identity can lead to discrimination. For GBT individuals, disclosing their sexuality, an internalized personal and marginalized aspect of identity, is a process often referred to as coming out (Griffith & Hebl, 2002). Due to stigma about same-sex relationships and a Western duality of gender, coming out can radically change the meaning and experience of family life

(Muraco et al., 2008). Many gay BB men started their coming out later in life, during their 30s and 40s, to a few select family members (Vaccaro, 2009). Some gay BB men have not come out to either of their parents (Muraco et al., 2008). The coming out process is different for each person. Some men report being surprised by receiving strong support from their families after coming out, whereas others report strained or alienated relationships with their children when coming out later in life (Muraco et al., 2008). Even while out, lesbian, gay, and bisexual BBs are selective about persons in whom they confide, as coming out is often associated with distance and strain in the family, with some responses being hostile and/or unsupportive (Vaccaro, 2009).

Being out is associated with an increased risk of discrimination and violence (Vaccaro, 2009). Although some states and workplaces have policies and legislation in place to protect GLBT individuals from discrimination, these measures are not universal. Further, even when such policies and legislation are in place, discrimination may still occur in subtle, non-verbal, and/or covert ways (Griffith & Hebl, 2002). Transgender men who transition later in life may have different experiences with their children and grandchildren than GB men due to less visibility and minimal layperson understanding of the transgender experience (Witten, 2009).

Summary of Baby Boomer Men and Caregiving

Baby Boomer men in the U.S. live in a gendered society with social expectations to embody and enact masculine norms. Traditional gender socialization for these men has often focused more on competition and work to define what being a man is and what

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it is not, while stigmatizing men who exhibit behaviors that are considered traditionally

feminine, such as men who exhibit sexual preference for other men or who appear

feminine (O'Neil, 2008). Gender role conflict occurs when men do not fit or deviate

from socially constructed male gender norms, including deviations that occur as the result

of men taking on caregiving roles (Doucet, 2006; Mahalik et al., 2001). Current trends in

BB men's lives, such as changing work roles, increased longevity of elders, and changing

family composition, most likely will result in more BB men taking on caregiving roles.

Discrimination in Society

In addition to growing older and managing finances, caregiving BB men face a

number of challenges due to various aspects of their identity. Individual social context,

including their socioeconomic status (SES), age, sexual orientation, and racial/ethnic

identity, impacts and interacts with psychological health and resources to manage

additional life stressors. For example, the multilayered interactions of aging, gay,

bisexual, and transgender identities, family, and society make in-depth/holistic research

into the BB experience challenging due to the difficulties associated with effectively

accessing marginalized populations (Witten, 2009).

Individuals can experience rejection and discrimination for any aspect of their

identity in different contexts at different times (Hulko, 2009). Some discrimination is

based on appearance and sometimes people face rejection or judgment due to a

behavioral aspect of part of their identity. Gay men often report a fear of rejection from

their families and communities when they are completely out about their sexual

orientation (Stacey, 2005). Gamarel, Reisner, Parsons, and Golub's (2012) study of

predominantly White (61% of the sample), educated (75%), and financially secure (71%)

BB gay men in New York City found multiple forms of discrimination caused depressive

and anxious symptoms. Within their sample, 63% reported heterosexism, 38% reported

racism, and 18% reported classism as their greatest concern (Gamarel et al., 2012).

Marginalized populations may experience discrimination in many different ways. At

systemic levels, marginalized people have lower levels of and/or access to housing,

education, employment, and laws that either actively discriminate against them or fail to

protect their basic human rights (Harper & Schneider, 2003). The individuals may also

experience physical and emotional harm. The use of the term discrimination in the

current study is inclusive of oppression, rejection, harassment, and violence.

Ageism

Individuals become increasingly susceptible to age-related discrimination as they

grow older. Ageism is defined as negative social attitudes toward aging and is pervasive

in the U.S. (North & Fiske, 2012). Ageism impacts multiple aspects of life, including

family, work/retirement, community networks, social and psychological research, and

public policies on social welfare and health care (North & Fiske, 2012; Rozanova,

Northcott, & McDaniel, 2006). BB men are currently transitioning from middle age of

30s-50 to older age of 50 and above (NAC/AARP, 2009). The perceptions of what men

should be like at various ages are influenced by multiple factors, such as health (Nelson,

2005). However, aging is also experienced in the context of a society that may make

increasing negative assumptions about abilities or experiences as individuals gets

progressively older (Nelson, 2005). Aging is a personal experience that is impacted by

how people understand what they think they should be like at a certain age.

Ageism can be experienced in many ways. Sometimes people have internalized

ageist beliefs. Internalized ageism, or self-stereotypes about aging, are negative sets of

implicit beliefs about age and aging (Levy, 2003). Internalized ageism can increase

anxiety and depression, especially when the aging individuals are managing multiple

stressors, including present and anticipatory stress about aging (Stacey, 2005). Gay,

bisexual, and transgender BB men may also have an additional fear of growing old alone

in part because they are more likely to be estranged from their family of origin than

heterosexual men (Muraco et al., 2008).

While individuals have different beliefs about their age, society imposes many

ageist beliefs, which often lead to discrimination in different contexts. When older

individuals perceived age discrimination, they reported lower self-esteem and life

satisfaction than young adults (Garstka, Schmitt, Branscombe, & Hummert, 2004). One

example of external ageism is age-related discrimination in employment. Multiple

cultural myths exist about older workers. Some of these beliefs include the belief that

older workers may lack of physical ability or stamina, the belief that older workers are

rigid and inflexible and therefore difficult to retrain, the belief that older workers are less

willing to learn and apply new technology, and the belief that older workers are more

costly due to lower productivity outputs and higher healthcare costs (Evans, Conte,

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Gilroy, Marvin, Theysohn, & Fisher, 2008; Schulz & Binstock, 2006). The reality seems

to be that older workers are none of these. In fact, older workers have lower rates of

absenteeism, have fewer disciplinary incident reports, and stay at their jobs longer than

younger workers (Schulz & Binstock, 2006). Many employers would rather hire younger

workers than support their older workers, so BBs are often encouraged into early

retirement explicitly or implicitly by employers, even though BBs would often rather

continue to work (Maples & Abney, 2006; McVittie, McKinlay, & Widdicombe, 2003;

Schulz & Binstock, 2006). The marginalization of older workers continues despite the

enactment of various equal opportunity measures explicitly aimed at reducing ageism

(McVittie et al., 2003).

Ageism may be even more prevalent in gay communities because of negative

aging stereotypes particular to those communities (Fox, 2007). Longino (2005) theorized

that ageist beliefs within the GBT community are directed at men earlier in the aging

process than occurs within the heterosexual community, and that this phenomenon

directly results from a combination of ageist and heterosexist beliefs. White gay men

report experiencing many ageist beliefs and behaviors from within their community,

which often defines old age as beginning as early as 39 years of age (Schope, 2005). Part

of the early ageism phenomenon in the gay community might be linked to sexual

objectification in gay culture, which parallels heterosexist attitudes toward women that

define individual value by youth and physical attractiveness (Stacey, 2005).

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Classism

Baby Boomer men may also be vulnerable to multiple financial stressors, including low income, unemployment, or lack of savings. As previously mentioned, BB men often continue to have family obligations well past the age of retirement. Variability of income, types of employment and education, liquid and illiquid assets, and even the ability to retire, intersects in a social and financial system known as class. Class refers to access to economic and political resources impacting life experiences from birth to death and "mediates and influences what a person is likely to learn, believe, anticipate, and seek after" (Lott, 2012, p. 650).

The U.S. is a classist society where the distribution of power and resources represents more than just socio-economic status (Bullock & Limbert, 2003). Socio-economic status (SES) encompasses health care and nutrition, access to education, housing, and employment, and even includes additional cost due to higher interest rates or out of pocket cost for emergency room health service because of lacking insurance for a primary care physician (Copen, 2006). While most people understand at some level that if they live long enough they will get older, they fail to consider the income and resources changes that are often tied to aging and lead to poverty. The myth of the meritocracy means that poverty is blamed on the poor, so older adults who become impoverished are considered victims of their own choices rather than victims of an ageist and classist society (Bullock & Limbert, 2003; Hunt, 2004; Shildrick & MacDonald, 2013). Classism may also be indirectly reflected in psychological research due to

difficulty in accessing lower SES samples for studies. For example, O'Neil's (2008) 25 year review of research on GRC found limited understanding of the impact of SES and class on GRC.

As BBs get older, they may be at an increased risk of poverty or need of welfare, particularly if they were not upper-middle class or wealthy prior to retirement. The Social Security Administration (2010) found that Social Security benefits account for the sole income of 13% of those 55-61, 43% of those 62-64, and jumping to 76% of those 65 years old or older. To maintain the quality of life they experienced prior to retirement, older people need to supplement savings, diminishing incomes, and limited pensions or other forms of retirement income; Social Security benefits alone are rarely sufficient by themselves. Independent living for the elderly is only possible with wealth gained from steady and sufficient income that allowed for some type of savings (Schulz & Binstock, 2006).

A cultural assumption in the U.S. is that when people get older they will retire at some point yet the reality is that retirement is a luxury not all older adults can afford (McManus, Anderberg, & Lazarus, 2007; Mock, Sedlovskaya, & Purdie-Vaughns, 2011). Most of the respondents in Evan et al.'s (2008) study reported a need to continue to work past the age of 55 to maintain their homes and lifestyles or because they had to pay out of pocket for health insurance. For those providing care to an elderly parent, additional personal medical costs were 11% for blue-collar caregivers and over 18% for caregiving men (Albert et al., 2010); thus, caregiving adults incur additional financial hardship that

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further necessitate some form of supplemental income beyond simply living on Social Security. These additional medical costs may at least partially result from the health consequences incurred from unhealthy or unsuccessful coping techniques used to cope with the stress of being a caregiver, such as the health effects of smoking or drinking alcohol(Albert et al., 2010).

Social class is often an inherited aspect of identity. Individuals are born into a SES with all the inherent shortcomings for the poor and privileges for the affluent. These differences in SES can impact health and access to income from birth to death. Intergenerational poverty is nearly an expectation in many parts of the U.S. (Barnes & Jaret, 2003; Jordan-Zachery, 2009; Sharkey, 2008). Intergenerational poverty is even more prominent in minority communities (Martorell & Zongrone, 2012). Due to expectations of continued poverty, minority families report more stress when thinking about finances and taking care of family member than White families (Rebbeck, Weber, Spangler, & Zeigler-Johnson, 2013).

Heterosexism

Same-sex attraction was labeled as a mental disorder until 1973 when the American Psychiatric Association finally removed homosexuality as a disorder from the *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed., American Psychiatric Association, 1973). Before 1973, those who admitted to same-sex attraction were submitted to horrible and abusive treatments. For example, in 1972, Tulane researchers implanted stainless steel electrodes into more than half a dozen sites of the brain to use

different voltages to eliminate the same-sex attraction and encourage heterosexual feelings (Baumeister, 2000). Gay, bisexual and transgender men also may face adverse reactions from family members and other health providers, such as involuntary testosterone injections designed to increase their masculine physical and psychological traits when they are adolescents or young adults, or forced/coerced participation in treatments, such as aversion therapy (Chapple, Kippax, & Smith, 1998). GBT caregivers may face the additional stressor of having to provide face-to-face caregiving to a family member who may be hostile, abusive, unsupportive or insensitive due to their sexual identity or gender transition (Witten, 2009).

Heterosexism is an "ideological system that denies, denigrated, and stigmatizes any non-heterosexual..." regarding behavior, identity, and relationships that creates exclusionary practices and invisibility (Herek, 1990, p. 317). Heterosexism can lead to acts of violence against those with same-sex attraction. These behaviors are often considered homophobic acts, where perpetrators have had minimal personal exposure to gay, lesbian, or bisexual peers or family members (Cullen, Wright, & Alessandri, 2002; Herek, 1990). In a sample of three major metropolitan cities in the U.S., more than 10% of gay Latinos reported experiencing violence directly related to their sexual orientation or feminine appearance (Díaz, Ayala, Bein, Henne, & Marin, 2001). Self-reported experiences of racial and heterosexist discrimination are negatively correlated with psychological well-being and physical health (Díaz et al., 2001).

Heterosexism is not only manifested by individual experiences of social discrimination; heterosexism is also enacted and embodied by legal policy limiting the privileges of non-heterosexuals. Heterosexism results in the experience of multiple forms of intersecting oppression for many gay and transgender BB men who also have other marginalized identities, such as minority racial status. For example, the lack of legal support for same-sex spousal benefits creates additional financial and social stress on gay and same-sex biracial couples, which are not experienced by any heterosexual couples who are legally married (de Vries, 2009; Knochel, 2010). Inability to marry also impacts spousal benefits and welfare programs designed to support grandparents raising grandchildren; the Temporary Aid to Needy Families'(TANF) focus on heterosexual two-parent families, so gay BB grandfathers have to struggle in each state to attempt to gain equivalent access to services (Copen, 2006).

Biphobia and transphobia. A current struggle for those individuals who experience marginalized sexuality and gender presentation is how legislation can continue to be exclusive by using limited word choice, such as "orientation" (Weiss, 2003). Due to heterosexist social and political forces disempowering those who do not fit heteronormative expectations, there is an externally imposed split between the gay/lesbian communities and bisexual/transgender communities, and these forces have consequences for the advocating for civil rights and community inclusion (Weiss, 2003).

Bisexuals do not fit the hetero- or homosexual binary of Western culture. Those who identify as bisexual often receive negative feedback from individuals of both

orientations (Paul, 1985; Weiss, 2003). If bisexual men are in relationships with other

men, they receive the heterosexist discrimination already mentioned. Bisexual

individuals often have the additional stressor of others invalidating them, expressing

beliefs that bisexuals are only experimenting and are actually either heterosexual or

homosexual, or their feelings are referred to as just a temporary phase (Deacon, Retake,

& Viers, 1996).

Transgender identity refers to persons whose gender identity expression may not

necessarily be the same gender they were assigned at birth (Hines, 2006). Since Western

society only acknowledges a gender binary of man or woman, transgender individuals fill

an ambiguous space and often experience discrimination. Transgender BB men may

have an atypical cohort experience due to gender experiences related to the age at which

they started their physical and/or social transition (Witten, 2009). In a national survey, as

many as 91% of transgender individuals reported having been a victim of perceived or

direct violence (Witten & Eyler, 1999). Transgender individuals have disproportionally

higher rates of low SES and poverty than those among the non-transgender population

(Witten, 2009).

After nearly a decade of research, Witten's (2009) hypothesis is that transgender

individuals might be at greater risk of negative life events due to discrimination directly

related to their transgender status. For example, many transgendered men also face the

additional stressor of the expecting and often receiving inappropriate or discriminatory

medical care due to biased beliefs and a lack of transgender positive education and

training among medical professionals (Witten, 2009). Aging transgender men have a valid fear of harassment and invalidation from doctors and nurses (Donovan, 2001).

Increased reproductive technology options have further complicated legal rights for transgender fathers. For example, transgender fathers might only be recognized as egg donors if their female spouses or partners gestate children from the fathers' implanted fertilized eggs (Pfeffer, 2010). While many heterosexual partnerships with one transgender individual survive the gender transition, the nature of the partnership may change, especially around issues of intimacy and parenting roles (Hines, 2006).

Racism

By 2030, the U.S. demographics will have shifted such that the population of racial/ethnic minorities will nearly match the current White majority in number through births and immigration; these minority groups will actually become the new majority by 2042 (U.S. Census Bureau, 2008). Currently, racist behaviors and beliefs are widespread in the U. S.; these behaviors and beliefs encompass a wide range of phenomena, including higher homicide rates for racial/ethnic minorities, higher incarceration rates among minority men, and the enactment of both physical violence and microaggressions (Federal Bureau of Investigation, 2011). Microaggressions are "brief, commonplace, and daily verbal, behavioral, and environmental slights and indignities," such as exclusive language or stereotypical assumptions (Sue, Capodilupo, & Holder, 2008, p. 329).

Racism is also more than just individuals acting against others who they perceive as different; it can also be institutionalized. Black and Hispanic men reported higher

rates of unemployment than White men and are adversely impacted by the types of jobs, pay, and benefits may be available to them, due to both overt and covert racism (Flippen & Tienda, 2000). Black workers reported high rates of employment instability and often report that they do not consider retirement to be a viable option as a result of the adverse economic impact of this instability (Flippen & Tienda, 2000). In recent meta-analyses of existing research, "racial discrimination was significantly and positively related to psychological distress..." among Black individuals (Lee & Ahn, 2013, p. 7), for Asian individuals (Lee & Ahn, 2011), and for Latino/a individuals (Lee & Ahn, 2012).

Racism is not limited to discriminatory attitudes and behaviors by White individuals toward racial/ethnic minorities; U.S. born minorities may also demonstrate such attitudes and behaviors toward immigrant minorities (Huber, Lopez, Malagon, Velez, & Solorzano, 2008; Tafira, 2011). Immigrant racism can be perpetrated from one marginalized group to another when one marginalized group believes that members of the other marginalized group are "socially and culturally inferior" (Tafira, 2011, p. 114). Immigration status, especially for those who migrate later in life, impacts aging, family roles, and increases the vulnerability to psychological distress from racism (Tafira, 2011).

Racism impacts family systems in multiple ways. A recent meta-analysis of research found that "greater perceived racism was associated with greater psychological distress..." in Black adults (Pieterse, Todd, Neville, & Carter, 2012). Mental health exists within multiple contexts, including families and society. Racial/ethnic minority families perceive racism in the U.S. as a barrier to safety and basic resources (Hawkins & Maurer,

2012). An example, when examining discrepancies between Black and White perinatal

mortality rates, some health caregivers would agree that racism continues to be a salient

concern in the U.S. (Alio, Richman, Clayton, Jeffers, Wathington, & Salihu, 2010).

Another example of racism impacting family systems can be seen whenlimited power and

resources over the life-span appear to compound psychological distress for older Black

individuals (Brooks, Kahana, Nauta, & Kahana, 2007). The previous examples provide

an understanding of a systemic context in which minority caregivers may perceive formal

mental health support as racist or are fearful of being culturally misunderstood (Rastogi,

Massey-Hastings, & Wieling, 2012).

How "Isms" may Impact Baby Boomer Men's Caregiving

        As previously mentioned, the experience of discrimination has been shown to

negatively impacts mental health, including stress and depression. Many BB men have

multiple marginalized identities and thus experience multiple forms of discrimination,

which may interact with each other. Limited research exists on the intersection of the

impact of discrimination and caregiving on men's psychological well-being. Most

studies examining racial/ethnic differences between caregivers have utilized primarily

female samples (Dilworth-Anderson et al., 2002). Due to their gender, men may have

different and unique experiences as caregivers. For example, traditional male gender

roles do not inoculate BB men from higher rates of depression, especially when perceived

racial/ethnic discrimination is reported (Matthews, Hammond, Nuru-Jeter, Cole-Lewis,

&Melvin, 2013). Multiple "isms" can be at least partially understood through the concept of intersectionality.

Intersectionality

There are many limitations to examining only one aspect of identity. A primary limitation in psychological studies is not attending to power differentials of participants. An example of inequality in power differential occurs when access to resources is limited based on physical appearance (Zinn & Dill, 1996). Age, gender, race/ethnicity, SES, or other marginalized statuses all compose part of social identities or intersections between identities (Cole, 2009). A single identity focus oversimplifies inequality and focuses on the majority at the exclusion of the experiences of the least privileged (Cole, 2009). Intersectionality theory posits that the possession of more than one marginalized social identity leads to unique manifestations of discrimination (Cole, 2009). These multiple dimensions of identity can interlock and compound any one experience of discriminations (Zinn & Dill, 1996). Bowleg, Teti, Malebranche, and Tschann (2013) have recently used intersectionality to explore discrimination and other negative life outcomes for Black men's experiences with gender role conflicts and minority identities. For example, an older, low-income Black man's experience with discrimination based on his social identity will be different and more complicated than a summative increase in ageism, classism, and racism.

People use their social identities to make sense of their place in the world, including how they interact with others. These complex identities inform and promote

certain cultural and structural realities about each aspect of the identity in addition to the

intersections within the identity as a whole, interacting in various ways and at different

times to influence peoples' lives (Cole, 2009). Intersectionality of identity needs to

include a discussion of social location, which is "the relative amount of privilege and

oppression that individuals possess on the basis of specific identity constructs" (Hulko,

2009, p.48). The previous example of a Black man's experience as a caregiver will be

interdependent and mutually derived from his other identities, which define his social

location and experiences (Cole, 2009; Hulko, 2009). His social location changes his

behavior and most likely his perceptions of his gender role socialization and other

identity expectations (Hulko, 2009). Multiple social identities cause a person to evaluate

and come into contact with conflicting norms based on each identity, including negative

stereotypes and discrimination (Hulko, 2009).

In examining the role of social location in understanding BB men's caregiving,

taking an intersectional approach will be imperative. The current researcher strived to

honor the complex intersections of age, class, sexual orientation, and race/ethnicity,

rather than "artificially separating these diversity dimensions" (Iwasaki et al., 2008, p.

703). The previous literature already reviewed has provided examples of how one or

more aspects of identity impact BB men's caregiving. A related question of note is how

BB men from both majority and minority social locations cope with the discrimination

that they may encounter in gender-atypical roles, such as caregiver.

Managing Discrimination

Individual attempts to cope with discrimination can take many forms and have been studied extensively. Representative findings are briefly presented here. One strategy for managing discrimination might be attempting to minimize exposure to situations in which discrimination could occur (Bowleg et al., 2003; Molero et al., 2011). Another individual strategy for reducing the negative impact of possible discrimination is to become an active part of a community, including faith membership and/or local civil rights activity (Molero et al., 2011). A study of college age Black and Hispanic students, with nearly 50% of participants being men, found that strong intra-group friendships were beneficial for minority individuals in combating the adverse psychological impact of discrimination. Strong intra-group friendships were positively related to feelings of social belonging as well as academic performance and motivation (Levin, van Laar, & Foote, 2006).

Many studies have also examined identity resilience when discrimination is unavoidable or pervasive (e.g., Bowleg et al., 2003). Several internal factors have been identified to help manage and navigate multiple marginalized identities. These include: (1) spiritual characteristics, such as feeling blessed to be a member of a minority group; (2) feelings of uniqueness and/or pride in their minority identity and community; (3) self-esteem; (4) behavioral and social competencies, such as social and problem-solving skills; and (5) a feeling of freedom from traditional expectations, optimism, and humor (Bowleg et al., 2003). Aligning with these factors, a strong connection with individuals'

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racial/ethnic communities can reduce anger and depression caused by discrimination

(Burt et al., 2012). Singh and McKleroy's (2010) qualitative study of ethnic minority

transgender persons found similar results, with two additional coping themes related to

flexibility in changing relationships within the family and the ability to access health care

and financial security.

Managing and coping with discrimination might look different for different

groups. Older adults, as a growing demographic, may cope with ageism by influencing

public policy, social understanding of aging, and financial aspects of society (North &

Fiske, 2012). Strong social support networks, positive self-concept, and positive belief in

others reduce negative outcomes from discrimination in Hispanic populations (Lee &

Ahn, 2012). Positive beliefs in others, social ties to the Black community, and a positive

internalized racial identity reduce psychological distress from discrimination in Black

populations (Lee & Ahn, 2013). Social support from individuals minority groups have

also been shown to be beneficial for gay men (Iwasaki et al., 2008).

Individual differences must also be considered. For example, individuals'

perspectives on discrimination impacts the psychological distress caused by

discrimination. In a study by Foster (2009), respondents who began to view

discrimination as a highly pervasive aspect of society exhibited different coping styles

than those who viewed discrimination as less pervasive. Individuals viewing

discrimination as more pervasive showed a corresponding decrease in isolation and

avoidance; their empowerment also increased and they began to use proactive, problem-

focused coping strategies geared towards resolving discrimination (Foster, 2009).

Additionally, stress from the intersectionality of discriminated identities is not always

viewed as negative; for some marginalized individuals, this stress can be a motivator for

growth and personal insight (Iwasaki et al., 2008).

Summary of Discrimination

The intersectional effects of ethnicity, income, sexual orientation, and gender

identity can collide for many BB men. All BB men are at risk for ageism, but BB men

vary in their risk for and impact from classism, heterosexism, and racism. Discrimination

has been shown to have a negative physical, emotional, and behavioral impact on men

(e.g., Hulko, 2009; Witten, 2009) and therefore may detrimentally impact their ability to

provide care to others because of impairments in internal and external resources. There is

a dearth of research on how BB men, particularly BB men possessing one or more

marginalized identities, negotiate caregiving and discrimination with finite resources,

including functional levels of stress, limited hours each day and week, and various levels

of financial flexibility.

Rationale for the Study

As previously noted, most caregiving studies have been conducted on White,

middle-to-upper income, heterosexual, married, highly educated, women participants

(Albert et al., 2010; Black et al., 2010; Finkelstein et al., 2012; Piercy & Chapman,

2001). In many studies, limited demographic information about the study participants

was provided, beyond gender, making it difficult to determine to what extent the results

are generalizable to various caregiving populations (O'Rourke et al., 2007). Because

attitudes and beliefs about family caregiving are impacted by race/ethnicity, income, and

education (Foley et al., 2002), it is important for caregiver studies to attempt to capture

larger samples from marginalized populations. More comprehensive research may then

allow therapists to provide more focused interventions and social advocacy. However,

few of these studies are available.

Unless a minority demographic was explicitly mentioned, most of the literature

review was extrapolated from research studies on White, heterosexual women. Existing

research on informal caregiving is strongly biased due to the under-reporting of the

experiences of minority caregivers (Dilworth-Anderson et al., 2002), while

simultaneously reporting a higher percentage of minority elders receiving informal care

(Weiss, González, Kabeto, & Langa, 2005). A large body of research exists on White,

middle class caregivers experiencing depression with feelings of being overwhelmed;

however, few of these studies included information about the sexual orientation of the

participants (Clark & Diamond, 2010; Finkelstein et al., 2012; Sewitch, McCusker,

Dendukuri, & Yaffe, 2004; Stephens et al., 2001). Most research on gay BB men has

been conducted on White, urban, heterosexual, educated men with high incomes (Biblarz

& Savci, 2010; Muraco et al., 2008; Murphy, 2013). These gaps in the literature need to

be addressed in order to inform policy decisions and expand services available to

caregivers in a manner that appropriately reflects the needs of a caregiving population

with changing demographics.

The current study utilized a feminist gerontological understanding of the experience of BB men to attempt to capture the unique experience of men in informal intergenerational family caregiving roles. Feminist theories acknowledge that individuals cannot be conceptualized in isolation of multiple socio-cultural variables, such as sexual orientation and ethnicity (American Psychological Association, 2007; 2012). Feminist theories also stress the potentially damaging mental health consequences that increase when multiple forms of oppression and other stressors coexist, especially for marginalized populations (APA, 2007, 2012). A feminist perspective on the meaning of caregiving focuses more on societal and moral expectations regarding family role obligations than on personal choice (Paoletti, 2002).

Feminist gerontology allows for an open dialogue on the impact of gender on social interactions across the life course (Calasanti, 2004). In other words, feminist gerontology is a feminist perspective on aging within a life course framework, which recognizes socio-political influences, such as discrimination (Hooyman et al., 2002). Feminist gerontology addresses gender as a social construct (Calasanti, 2004) in a manner similar to gender role conflict studies (O'Neil, 2008). When speaking of gender and aging as social constructs, feminist gerontologists explore sociocultural and socioeconomic forces where:

> …political and socioeconomic factors interact to shape the experience of
> aging, and it regards gender, ethnic background, and social class as
> variables on which the life course of individuals pivot, insofar as it

predetermines their position in the social order… .(Freixas, Luque, &

Reina, 2012, pp. 44-45)

Calasanti (2004) explores men and masculinity in the social construct of dominant

masculinity. Aging and elderly men challenge the dominant paradigm of masculinity as

associated with strength, independence, wealth, and emotional self-control. The

paradigm of masculinity also intersects with a discussion of older men and caregiving as

Freixas et al.'s (2012) research shows in the disempowerment process also inherent in

uncompensated caregiving.

As more men become caregivers and as the racial/ethnic demographics of the U.S.

change, both researchers and practitioners could benefit from understanding experiences

of diverse caregivers. The current study's goal was to explore the experiences of

caregivers least represented in current research. The study utilized a multicultural,

feminist framework in the contextualization and interpretation of the intersectionality of

diverse identities present in BB men. This framework informed the studies literature

review and was applied in the discussion of the study's results.

Research Question

In an attempt to gain a more holistic understanding of BB men in caregiving roles,

the current study strived to improve on previous research by exploring within- as well as

between-group differences. The current study examined similarities and differences in

caregiving roles, the impact of discrimination, and psychological distress of diverse BB

men who are providing informal family care. The study asked the broad question: What

impact does discrimination have on the relationship between intergenerational caregiving

and psychological distress for diverse Baby Boomer men? Specific hypotheses related to

this research question are covered in the Methods chapter, which follows.

Hypotheses

The following hypotheses were proposed:

H1. There would be a statistically significant positive relationship between psychological

distress and discrimination among caregivers supplying high amounts of ADL.

H2. There would be a statistically significant positive relationship between psychological

distress and discrimination among caregivers supplying a high number of hours a week

caregiving.

H3. Discrimination would not have a statistically significant influence psychological

distress for those providing high amounts of IADL.

H4. Perception of respite support would moderate the relationship between social

support and psychological distress. Specifically, high perception of respite would

statistically significant decrease psychological distress for those with low social support.

CHAPTER III

METHOD

This chapter will detail the sampling/participants, instruments, and procedures for the present study. Research questions and specific hypotheses with their respective analyses are presented at the end of the chapter.

Participants

A sample of 153 Baby Boomer men was sought for this study, as determined by utilizing the G*Power program for power analysis. The Baby Boomer generation is defined as those born during 1946-1964. Men included those born biologically male as well as those who identify as men, including transgender men or transgender female-to-male participants. Two hundred and twenty-six participants accessed the online survey. Seventy-two of the 226 surveys were accessed without being completed by the participants and were unusable for any statistical analysis. One hundred and fifty-four surveys were utilized in the final data analysis.

The sample was largely White, heterosexual, middle-class, in good health, and had some post-high school education, though some variation was present. Table 1 provides the demographic frequencies and percentages.

Table 1

Frequencies and Percentages for Categorical Demographic Variables

	Caregiver		Non-Caregiver	
	n	%	n	%
Sexual Orientation				
Heterosexual	94	96.9	46	80.7
Gay	1	1.0	0	0
Bisexual	2	2.1	11	19.3
Years in School				
Less than 12 years	2	2.0	1	1.8
12	18	18.6	8	14.0
13	4	4.1	1	1.8
14	12	12.4	8	14.0
15	4	4.1	7	12.3
16	33	34.0	23	40.4
17	5	5.2	4	7.0
18	12	12.4	3	5.3
19 to 26 years	7	7.0	2	3.8
Ethnicity				
American Indian/Alaskan Native/Inuit	8	8.2	2	3.5
Black/African American	7	7.2	6	10.5
East Asian/Asian American	2	2.1	3	5.3
Latino/Hispanic	0	0	1	1.8
South Asian/Asian Indian	8	8.2	11	19.3
White/Caucasian	72	74.2	34	59.6
Income				
Did not provide	4	4.2	1	1.8
2,000-9,000	2	2.0	1	1.8
10,000-50,000	43	44.3	31	54.6
51,000-70,000	17	17.6	9	15.9
75,000-96,500	12	12.4	6	10.5
1000,000-300,000	19	19.5	8	14.1
500,000	0	0	1	1.8
Health				
Very good	24	24.7	14	24.6
Good	50	51.5	28	49.1
Neutral	22	22.7	12	21.1
Poor	1	1.0	3	5.3

One hundred and eighty-one participants from the total study chose a charity and the researcher honored all participants who chose a charity even if they did not answer any other aspect of the study. The breakdown of donations was $73 for the Alzheimer's Association, $75 for MD Anderson Cancer Research, and $33 for the Human Rights Campaign.

Instrumentation

In addition to basic demographics, several scales were administered to participants to examine psychological distress, what type and amount of care participants provided, perceived discrimination, and assessments of caregiver social resources. Each instrument is described below.

Demographic and General Information Questionnaire

The demographic and general information questionnaire was an author-generated instrument created for the current study. The questionnaire contained11 items related to various aspects of social location: birth year, sexual orientation, gender, ethnicity, years of education, yearly income, relationship with care recipient, years providing care, duration (i.e., months and years) providing care, availability of respite, and caregiver health status (See Appendix A). The item related to caregiver health status was composed of a subjective health question, which has been used in utilized in multiple studies (e.g., NAC/AARP, 2009; O'Rourke et al., 2007; Williams et al., 1997) about participants' perception of their current health. The availability of respite item was

composed of a subjective question to assess confidence in being able to receive respite

support and has precedent in the literature (e.g., Hanson, Tetley, & Clarke, 1999).

Hopkins Symptom Checklist-58 (HSCL-58)

The HSCL-58 is a 58-item scale has a total score measuring psychological

distress, including somatization, obsessive/compulsive, interpersonal sensitivity,

depression, and anxiety (See Appendix B; Derogatis, Lipman, Rickels, Uhlenhuth, &

Covi, 1974). The HSCL-58 was designed to assess distress based on recent

psychopathology (Braton, 2012). The HSCL-58 has developed into the SCL-90 and

SCL-90-R by authors who had published previous papers together (Braton, 2012;

Derogatis et al., 1974). The differences between the HSCL-58 and SCL-90 are sub-

scales added to measure phobic anxiety, paranoid ideation, psychoticism, and hostility

(Derogatis, n.d.). The SCL-90 differs from the SCL-90-R in the replacement of a two

items and changes in the phrasing of seven others (Braton, 2012; Derogatis, 1977). There

is some evidence suggesting "the SCL-90-R performs poorly at discriminating between

diagnostic categories within mental illness but performs favorably as a screening

instrument for mental illness generally" (Braton, 2012, p. 17).

Care Provided

The assessment of care being provided utilized modifications of two standardized

scales, the Lawton Instrumental Activities of Daily Living Scale (L-IADL; Lawton

&Brody, 1969; See Appendix C) and the Katz Index of Independence in Activities of

Daily Living (KII-ADL; Katz, Downs, Cash, & Grotz, 1970; See Appendix D).See

Appendix E for copyright permission for the L-IADL and Appendix F for copyright permission for the KII-ADL. Most current studies do not use a standardized scale yet appear to be adopted from these sources (Miller, Shoemaker, Willyard, & Addison, 2008; NAC/AARP, 2009; Piercy & Chapman, 2001). The current study differentiated between instrumental activities of daily living (IADL) and activities of daily living (ADL) for several reasons. One reason discussed in the literature review was that studies differentiating gender and type of care reported gender differences in caregiving with men performing more IADL and fewer ADL (e.g., Haefele, 2010). Additionally, differentiating ADL and IADL align with previous research on the differences in caregiver's perceived levels of burden, psychological distress, and commitment varies between these types of care, with ADL being more difficult for caregivers than IADL (Miller et al., 2008; Morse, Shaffer, Williamson, Dooley, & Schulz, 2012).

Instrumental Activities of Daily Living Scale. The IADL is a modification of the L-IADL (Lawton & Brody, 1969), with more contemporary instrumental activities of daily living checklists (e.g. NAC/AARP, 2009). The modifications were made to be inclusive of intergenerational caregiving and to capture the difference between participant caregiving and the caregiving of another person. The IADL remains true to Lawton and Brody's (1969) format of 8-domains of function: ability to use the telephone, shopping, food preparation, housekeeping, laundry, transportation, responsibility for own medications, and financial management. Participants choose 1 if they assist in a domain or 0 if the care recipient does not need a specific type of care or another person provides

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that type of care. A summary score ranges from 0 to 8, with higher scores indicating

higher care recipient dependence on caregiving provided by participant. The original

inter-rater reliability of the L-IADLwas established at 0.85 (Lawton & Brody, 1969).

Activities of Daily Living Index. The ADLI is adapted from the KII-ADL (Katz,

Downs, Cash, & Grotz, 1970) and similar unstructured checklists (e.g., NAC/AARP,

2009). Modifications were made to be inclusive of intergenerational caregiving and to

capture the difference between participant caregiving and the caregiving of another

person. The ADLI remains true to Katz et al.'s (1969) format of 5-domains of function:

bathing, dressing, toileting, transferring, and feeding. Participants chose 1 if they assist

in a domain or 0 if the care recipient does not need a specific type of care or another

person provides that type of care. A summary score ranges from 0 to 5, with higher

scores indicating higher care recipient dependence on caregiving provided by participant.

The Everyday Discrimination Scale

The Everyday Discrimination Scale (EDS; See Appendix G) reports participants'

perception of experiencing interpersonal discrimination (Williams et al., 1997; Williams,

2012). See Appendix H for communications with Williams indicating that no permission

is needed for use of scale. The EDS scale development was normed on Black, White,

and Latino participants with a Cronbach's alpha of 0.88 (Williams et al., 1997). Williams

et al. (1997) found Black participants to be twice as likely to report two more

discriminatory experiences as White participants and were seven times more likely than

White participants to report three experiences. Studies of validity and reliability have

shown the EDS to be a stable assessment of discrimination, with a Cronbach's $\alpha = 0.74$ or greater (Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005). Structural equation modeling demonstrated the EDS had a high correlation (r=0.79) to discrimination constructs associated with psychological distress (Krieger et al., 2005). The EDS was also found to be a valid measure of discrimination when comparing Black, Chinese, Hispanic, Japanese, and White women after adjusting for age, education, and language (Lewis, Yang, Jacobs, & Fitchett, 2012).

The EDS allows flexibility in assessing multiple aspects of discrimination and level of discrimination. There are 9-items on the EDS that receive Likert scale ratings. Participants are asked to assess their daily interactions with others and their perception of these interactions, including "You are called names or insulted" and "You receive poorer service than other people at restaurants or stores." Participants report the frequency of these interactions: 0-Never, 1-Less than once a year, 2-A few times a year, 3-A few times a month, 4-At least once a week, 5-Almost every day. Scores range from 0-45, with higher scores indicating higher levels of discrimination. There is one follow-up question asked only of those answering "A few times a year" or more frequently to at least one question, which allows participants' perception of the reason for the discrimination by checking one or two possible aspect of their social location (Williams, 2012). Participants are allowed to provide a qualitative response if they believe they are discriminated against for a reason not listed.

Perceived Social Support for Caregivers

The Perceived Social Support for Caregivers (PSSC; Goodman & Goodman, 1991; See Appendix I) does not require permission for use in student dissertations. The PSSC uses 9-items to evaluate the presence and utilization of caregiver social support. Participants evaluate each item on a 5-point Likert scale: 0-not at all, 1-almost never, 2-sometimes, 3-fairly often, or 4-very often. The types of support include understanding, receiving/sharing information, advice, emotional support, and universality of the caregiver experience versus feelings of isolation (Goodman & Goodman, 1991). Goodman and Goodman (1991) reported the PSSC's Cronbach's $\alpha= 0.84$. Kung (2003) used the PSSC for a study on caregivers of Chinese American caregivers of recipients with schizophrenia and reports a Cronbach's $\alpha= 0.80$.

Procedure

Prior to any data collection, the investigation obtained Institutional Review Board (IRB) approval. Participants were recruited through a post via the researcher on Facebook (See Appendix J for Solicitation Request). An additional snowball sampling recruitment was utilized as participants were asked to repost the link to the study if they have any BB men friends or family members who might be interested in participating in this research. An online survey was used to access a broad and diverse sample, which has been missing in previous research on Baby Boomers (Biblarz & Savci, 2010; Clark & Diamond, 2010; Finkelstein et al., 2012; Muraco et al., 2008; Murphy, 2013; Sewitch et al., 2004; Stephens et al., 2001). For example, over 50% of informal family caregivers

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say they have used the Internet in the past year to find caregiving information (NAC/AARP, 2009).

On the recruitment document, participants were asked to click on a survey link. The link led participants to the study, which first contained an informed consent document. The Informed Consent document (See Appendix K) discussed confidentiality and offered the assurance that participants' online survey responses would not be traced back to their computer by the researcher (Riggle, Rostosky, & Reedy, 2005). The informed consent documented the eligibility requirements of the study, potential risks, and benefits to participants, and the confidentiality of the data collected.

Access to the survey was hosted on PsychData and Amazon's Mechanical Turk. PsychData hosts the survey and compiles the data (PsychData, n.d.). PsychData addresses security as a top priority and only the researcher could access and view study results. PsychData uses a Secure Survey Environment for encoded data transmission and storage, which prevents the entire survey to be viewed by using the "Back" button. The dynamic server will store the survey, so the surveys will not be held on participants' computers. The encryption also used redundantly coded data on the servers, and once the survey was completed, the system prompted participants to close their browser window (PsychData, n.d.). Amazon's Mechanical Turk (MTurk; 2009) is a web site that recruits a workforce to participate in online surveys. MTurk maintains confidentiality of participants in that the only information provided to link participants to a response was a randomly generated cryptic number/letter identification, which is kept separate from the

research study (MTurk, 2009). All data transmissions were encrypted and Amazon

handled all financial transactions as an additional way to maintain the privacy of

participants' identities (MTurk, 2009). Participants on MTurk's web site were able to

preview the entire survey to gauge whether any offer of compensation was fair and

whether the task interested them before they accepted the Informed Consent and joined

the survey. Participants could withdraw their consent without penalty by clicking on the

"Return HIT" button or closing their web browser window (MTurk, 2009). The order of

the instruments was not counterbalanced as this was not possible in Amazon Mechanical

Turk.

At the end of the surveys, participants encountered a Thank You screen on which

they were again provided with American Psychological Association's free referral line

(1-800-964-2000) and web site http://locator.apa.org/, which was also previously

provided on the Informed Consent page. Participants were also directed to a separate link

to request results of the study so that their surveys and requests for results could never be

linked to each other.

An incentive to participate was mentioned in the recruitment form and detailed in

the informed consent. Participants chose between two web sites with two types of

incentives depending on which survey web site they choose, as defined on the Informed

Consent form. Participants chose to have the researcher make a charity donation at the

end of the survey by choosing the Psychdata.com link. The charity choices were defined

in the Informed Consent form and included the Alzheimer's Association, MD Anderson

Cancer Research, or Human Rights Campaign. The researcher donated one dollar for

each participant's time. Donations to the three organizations were made by a personal

check from this researcher at the conclusion of the data collection; participants will

always remain anonymous and their responses confidential. Participants who chose to

click on the Mechanical Turk link received one cent per question and receive up to $1.09

for their participation.

Statistical Analysis Plan

Descriptive Statistics

Basic descriptive statistics were run on all variables prior to the analysis of the

primary hypotheses. A correlation matrix examining basic relationships was also run.

Sexual orientation was coded for 1 for self-identification as heterosexual and as 0 for

self-identification as any other sexual orientation 0 due to the small number of

participants identifying as something other than heterosexual. Ethnicity was coded for 1

for self-identification as White/Caucasian and as 0 for self-identification as any other

ethnicity 0 due to the small number of participants identifying as something other than

White/Caucasian.

Primary Hypotheses

The purpose of the current study was to examine the relationships between

discrimination, caregiving, and psychological distress. Discrimination was examined as a

moderator of the relation between caregiving role and the experience of psychological

distress for BB men. Caregiving roles were assessed by weekly time spent caregiving

and amount of ADL and IADL provided. Additionally, to capture the psychological experience of caregiving BB men, the current study explored the role of perceived respite as a moderator of the relationship between social support and psychological distress. This study included four hypotheses, which are exploratory, based on the novel nature of examining the relationships between caregiving, discrimination, and psychological distress in BB men. The hypotheses were situated within a body of research, which has demonstrated that the demands of more caregiving time and ADL create elevated feelings of psychological distress for some caregivers (NAC/AARP, 2009).

Hierarchical multiple regression. The steps outlined by Aiken and West (1991; see also Dearing & Hamilton, 2006), were used to test for moderation. Each caregiving variable (i.e., ADL, hours a week spent caregiving, and IADL) was examined in a separate analysis. Prior to regression analyses, data were screened, and the assumptions of multiple regressions (i.e., independent of residuals, normality of residuals, linearity, and homoscedasticity), were assessed (Aiken & West, 1991; Osborne & Waters, 2002).

Since the researcher sought to determine if discrimination interacts with caregiving in predicting perceived psychological distress, three parallel analyses were conducted, assessing the three hypotheses on ADL, hours a week spent caregiving, and IADL. Discrimination and all three caregiving variables were centered prior to regression analyses. The variables were centered by following the guidelines established by Aiken and West (1991), subtracting the mean of the variables from each datum such that the means of the new centered variables will be zero.

Three parallel analyses were conducted for each of the caregiving variables. For each analysis, in Step 1, the caregiving variable (i.e., ADL, hours a week spent caregiving, and IADL) and perceived discrimination were entered into the regression equation. In Step 2, the interactions of discrimination with a caregiving variable was added, allowing a determination of the variance accounted for by adding the interaction term. Following Aiken and West (1991), the researcher graphed any significant interaction by calculating predicted values of psychological distress at high and low values of caregiving role and discrimination (+/- 1 SD).

Additionally, the researcher sought to determine if respite interacts with social support in predicting perceived psychological distress. Prior to regression analyses, data were screened and the assumptions of multiple regressions were assessed (Aiken & West, 1991; Osborne & Waters, 2002). Respite and social support variables were centered prior to regression analyses. The variables were centered (Aiken & West, 1991); subtracting the mean of the variables from each datum such that the means of the new centered variables will be zero. Step 1, respite and social support were entered into the regression equation. In Step 2, the interaction of respite and social support was added, allowing a determination of the variance accounted for by adding the interaction term.

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CHAPTER IV

RESULTS

Descriptive Statistics

Basic descriptive statistics were run on all the instruments administered in this

investigation. They are reported in Table 2.

Table 2

Descriptive Statistics for Study Measures

Measure	*M*	*SD*	Actual Range	Possible Range
Activities of Daily Living	1.08	1.38	0-5	0-5
Hours per Week of Caregiving	13.25	2.35	.25-34	Less than an hour (1)-More than 30 hours (8)
Instrumental Activities of Daily Living	2.68	1.98	1-7	0-8
Access to Respite	3.66	1.21	1-5	Not sure at all (1)-Certain (5)
Perceived Social Support for Caregivers	27.26	5.80	10-40	0-36
Psychological Distress	92.28	30.51	58-191	1-232
Perception of Discrimination	10.03	9.14	0-36	0-45

In addition, a correlation matrix was run to examine basic associations between

the study measures and demographics. This table is located in Appendix L due to its size.

Discrimination and psychological distress had a strong positive relationship with each

other ($r=.659$). Self-identifying as White racial/ethnic had a strong negative relationship

with both discrimination (*r*=-.535; specifically discrimination for age and ethnicity) and

with sexual orientation (*r*=-.440). Psychological distress and ethnicity were also

negatively correlated (*r*=-.508). Similar to findings in previous research (Bonnet et al.,

2011; NAC/AARP, 2009) performance of activities of daily living (ADL) by caregivers

had a stronger positive relationship with psychological distress (*r*=.495) than

performance of instrumental activities of daily living (IADL, *r*=.332). Additional

moderate relationships were noted between sexual orientation and psychological distress

(*r*=.396) and discrimination (*r*=.348).

Psychological distress was assessed using mean scores on the Hopkins Symptom

Checklist-58 (HSCL-58), a self-report measure on which participants responded to

multiple questions relating to different aspects of distress using a Likert scale rating. A

t-test did not show a statistically significant difference, $t(153) = 0.493067$, $p< .001$, in

psychological distress between those who identified themselves as caregivers ($M =$

92.52, $SD = 30.80$)and those who did not report providing care($M = 91.88$, $SD = 30.28$).

Discrimination was assessed using the mean of perceived discrimination on the

Perceived Social Support for Caregivers (PSSC). A *t-test* did not show a statistically

significant difference, $t(153) = 0.367598$, $p < .001$, between the perceptions of

discrimination between caregivers (n=97, $M = 9.26$, $SD = 8.60$)and non-caregivers(n=57,

$M = 11.33$, $SD = 9.94$). The most common form of discrimination reported was ageism,

followed by racism, then income, and lastly sexual orientation. One man added that being

a widow and another stated homelessness was a source of discrimination for him and four

reported they perceived personal discrimination for their weight/size. Notable is that the

majority of participants reported no discrimination in any of the categories presented

("Does not apply;" see Table 3).

Table 3

Source of Discrimination and Number of Participants Who Endorsed Type of Discrimination

	Does Not Apply	Primary Reason	Secondary Reason
Age	65	38	23
Education/Income Level	77	28	20
Race/Ethnicity	86	33	6
Sexual Orientation/Gender Presentation	98	18	10

By and large, the sample did not report perceptions of discrimination, and a series

of Chi Square tests showed no significant differences between caregivers and non-

caregivers on perceptions of ageism $\chi^2(1, N = 154) = .77$, $p = .681$, classism $\chi^2(1, N = 154) = .092$, $p = .955$, racism $\chi^2(1, N = 154) = .3.985$, $p = .136$, or heterosexism $\chi^2(1, N = 154) = .3.077$, $p = .215$. When caregivers did report discrimination, the most frequently

mentioned area was age, followed by followed by racism, then income, and lastly sexual

orientation. Caregivers reported that their age was the primary area of discrimination

followed by some form of classism as captured by perception of discrimination toward

education and/or income levels. Non-caregivers perceived that their race/ethnicity was

the primary category for perceptions of discrimination. The breakdown of frequencies of

perceived discrimination between caregivers and non-caregivers is provided in Table 4.

Table 4

Frequencies in Discrimination between Caregivers and Non-Caregivers

	Caregivers			Non-Caregivers		
	Does Not Apply	Primary Reason	Secondary Reason	Does Not Apply	Primary Reason	Secondary Reason
Age	39	26	15	26	12	8
Education/ Income	48	18	12	29	10	8
Race/Ethnicity	60	17	3	26	16	3
Sexual Orientation	64	8	7	34	10	3
Not Listed	57	11	8	35	7	2

Caregiving. Ninety-seven participants identified as caregivers. Recipients were asked to enter the age of their care recipient (see Table5). Almost half of the care recipients were elderly adults, with the other half divided almost equally between care recipients ages 19 to 64and between dependents 18 years and younger.

Table 5

Care Recipients Age

Category	n
Infant to 2 years	5
Children ages 3 to 5	7
School age children 6-18	17
Adults ages 19 to 64	23
Elderly care recipients ages ≥65	43

It should be noted that the wide variation in the age of care recipients is also evident in examining overall range, mean, and standard deviation for this data: $M = 47.5$ years, $SD = 33.1$ years, range: 6 months-98 years of age.

Recipients were asked to enter the relationship that they have with the care recipient and an automatic recoding was run on the data after the researcher recoded the variables into categorical nominal variables. Ninety-five participants provided their relationship to their care recipient (see Table 6).

Table6

Categories of Relationship to Caregivers

Type of Relationship	Total *n*	Sub-category *n*
Non-family members	1	
Child of participants	21	
Sons		11
Daughters		8
Child		1
Step-son		1
Spouse	4	
Wife		3
Ex-wife		1
Parent	41	
Mother		29
Father		5
Mother-in-law		3
Father-in-law		1
Step-mother		1
Grandchildren	21	
Grandchild		10
Grandchildren		10
Great-grandchild		1
Other Family Members	5	
Sister		4
Aunt		1

All 97 caregiving participants identified how many hours a week they spent providing care (see Table 7). Most provided care less than 20 hours a week. More than a quarter of the participants provided more than 21 hours a week of care.

Table 7

Hours a Week Providing Care

Amount of Time a Week	*n*
< 1 hour a week	9
1-5 hours	18
6-10 hours	22
11-20 hours	17
21-30 hours	13
>30 hours a week	18

M = 4.25 hours, *SD* = 2.35 hours, range: less 1 hour a week – more than 30 hours

All 97 caregiver participants supplied data on how long they had been engaged in providing care at the time of survey (see Table 8). Most had provided care for four years or less. However, roughly one-third had been involved in longer-term care of 5-36 years.

Table8

Length of Time Providing Care

Length of Time	*n*
<1 year of caregiving	57
1 year - 4 years	38
5 years - 10 years	24
11 years - 15 years	10
16 years - 20 years	8
21 years up to 36 years	5

M = 7.01, *SD* = 8.55, range: 2 months-36 years

Hypothesis 1

The first hypothesis stated that there will be a statistically significant positive relationship between psychological distress and discrimination among caregivers supplying high amounts of ADL. The specific predictors were: Hopkins Symptom Checklist-58 (HSCL-58) to assess psychological distress and The Everyday Discrimination Scale (EDS). A multiple regression analysis was conducted as outlined above to examine discrimination as a moderator of the relation between providing ADLs and psychological distress. Results indicated that, overall, the model predicted psychological distress, $F (3, 93) = 42.106$, $p<.01$. Perception of discrimination and performance of ADLs both positively predicted psychological distress (see Table 9). However, the interaction between perceived discrimination and performance of ADLs was not significant.

Table 9

Hypothesis 1: Perceived Discrimination and Performance of ADLs

	R^2	ΔR^2	B	$SE\ B$	β
Predictor					
Step 1	.570	.570**			
Discrimination			2.17	.26	.61**
ADL			6.40	1.61	.29**
Step 2	.576	.006			
Discrimination			2.10	.27	.59**
ADL			6.38	1.60	.29**
Discriminationx ADL			.23	.20	.25

** $p<.01$.

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Hypothesis 2

The second hypothesis stated that there will be a statistically significant positive relationship between psychological distress and discrimination among caregivers supplying a high number of hours a week caregiving. The specific predictors were: the HSCL-58 and the Everyday Discrimination Scale (EDS). A multiple regression analysis was conducted to explore the relationship between number of hours per week providing caregiving and rates of reported distress symptoms and perceptions of discrimination. Results indicated that, overall, the model predicted psychological distress, $F(3, 93) = 30.941$, $p<.01$. Perception of discrimination and hours a week caregiving both positively predicted psychological distress. The interaction between perception of discrimination and number of hours a week spent caregiving was not significant (see Table 10).

Table 10

Hypothesis 2: Perceived Discrimination and Hours a Week Providing Care

	R^2	ΔR^2	B	$SE\ B$	β
Predictor					
Step 1	.499	.499**			
Discrimination			2.52	.26	.70**
Hours			.62	.96	.05
Step 2	.500	.000			
Discrimination			2.52	.26	.70**
Hours			.60	.97	.05
Discriminationx Hours			-.02	.12	-.01

** $p<.01$.

Hypothesis 3

The third hypothesis stated that there will be a statistically significant negative

relationship between discrimination and psychological distress for those providing high

amounts of IADLs. The specific predictors were the HSCL-58 and the EDS. A multiple

regression analysis was conducted to explore the relationship between amount of IADLs

provided, rates of reported distress symptoms, and perceptions of discrimination. Results

indicated that, overall, the model predicted psychological distress, F (3, 93) = 32.401,

$p<.001$. Perception of discrimination and number of IADL the caregiver provides both

positively predict psychological distress. However, the interaction between

discrimination and number of IADL provided was not significant (see Table 11).

Table 11

Hypothesis 3: Perceived Discrimination and Performance of IADLs

		R^2	ΔR^2	B	$SE\ B$	β
Predictor						
Step 1		.511	.110**			
	Discrimination			2.39	.27	.67**
	IADL			1.93	1.19	.12
Step 2		.511	.000			
	Discrimination			2.38	.29	.66**
	IADL			1.95	1.20	.13
	DiscriminationxIADL			.01	.13	.01

** p<.01.

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Hypothesis 4

The fourth hypothesis stated that the perception of respite support will moderate the relationship between social support and psychological distress. Specifically, high perception of respite will statistically significant decrease psychological distress for those with low social support. The specific predictors were: HSCL-58, availability of respite, and the Perceived Social Support for Caregivers (PSSC). A multiple regression analysis was conducted to explore the relationship between PSSC, access to respite, and psychological distress. The overall regression model was not significant, $F (3, 93) =$ 1.503, $p=.01$. Respite was a marginally significant predictor of distress. The interaction between perception of social support and respite was not significant (see Table 12).

Table 12

Hypothesis 4: Respite and Presence of Social Support for Caregivers

		R^2	ΔR^2	B	$SE\ B$	β
Predictor						
Step 1		.041	.041			
	PSSC			.47	.54	.09
	Respite			-4.85	2.59	-.19**
Step 2		.046	.005			
	PCCS			.47	.54	.09
	Respite			-4.88	2.60	-.19**
	PSSCxRespite			.32	.45	.07

** p<.01.

Exploratory Factor Analyses

As the PSSC proved to be weak in the regression, this researcher conducted a factor analysis of the instrument (see Table 13). The current study results may have shown that the scale has a poor validity for Baby Boomer (BB) men. A factor analysis is used to assess reliability because results can be used to explore the relationships among variables. The factor analysis can be used to ascertain the most parsimonious number of factors required to explain the correlations among the variables then allows a researcher explore how the variables maybe interacting, or identifying the different factors(Thompson, 2004).Goodman and Goodman (1991) defined support as components of understanding, receiving/sharing information, advice, emotional support, and universality of the caregiver experience versus feelings of isolation. Using an exploratory factor analysis, the current study found that the older male participants of the current study showed two factors being assessed by the PSSC. One factor could be called Social and Emotional Support (PSSC 1, 2, 5, 6, and 8) and the other factor could be called Information Support (PSSC questions 3, 4, and 7).A scree plot shows two of those factors explained most of the variability. Factor 1 accounts for 49.5% of the total variance and factor 2 accounts for 12.7% (see Table 13). The remaining factors explain a very small proportion of the variability and thus are likely statistically irrelevant. An additional multiple regression analysis for each factor into hypothesis three, relationship between discrimination, distress and number of IADLs, on continued to yield a model

that was not significant: F (3, 93) = 1.140, p=.337 for Social Emotional Support; and F

(3, 93) = 1.690, p=.175 for Information Support.

Table 13

Principle Components Analysis with Varimax Rotation and Cronbach's Reliability Coefficient for the 9-items in the Perceived Social Support for Caregivers (PSSC)

	Factor 1	Factor 2
Factor 1: Social and Emotional Support		
1. I can talk over my feelings about caregiving with others who have similar values.	.740	
2. Others I know have helped me deal with frustrations I have as a result of being a caregiver.	.683	
5. I know someone who understands the difficulties I face as a caregiver.	.786	
7. Others I know have helped me realize my problems are not unique.	.741	
9. Overall, I feel satisfied with support I receive from others as I take care of my relative.	.743	
Factor 2: Information Support		
3. Others I know have given me useful advice about how to plan for the future.		.790
4. Others have helped me gain insight into my behavior and feelings as caregiver.		.811
6. Others I know have given me information about the concerns of my family member receive my care.		.678
8. I've learned from others I know by watching how they manage stress.		.751
α	0.742	0.671
Eigenvalue	4.46	1.14

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CHAPTER V

DISCUSSION

The present study sought to examine the relationship between discrimination, caregiving roles, and psychological distress within the Baby Boomer (BB) cohort of men. The specific topics of interest were the impact of perceived discrimination on the relationship between amounts of activities of daily living (ADL) caregivers provide, hours a week providing care, amount of instrumental activities of daily living (IADL) caregivers provide, and psychological distress for Baby Boomer men. While findings support that discrimination, hours of providing caregiving, as well as both types of caregiving (ADL and IADL) were correlated with psychological distress, none of the interactions were statistically significant. The secondary hypothesis of the study was to examine the relationship of caregiving BB men's use of respite and social support and psychological distress. The current study did not find significant relationships among any of these variables.

Integration with Previous Literature

The present study addresses the dearth of existing research relating to caregiving men (e.g., Baker, Roberston, & Connelly, 2010; Conde-Sala, 2009; del-Pino-Casado, 2010; Mitrani et al., 2006; Robertson et al., 2007). To date, research on male caregiving has focused on men who provide care to wives and spouses only (e.g., Adams et al., 2002; Baker et al., 2010; Black et al., 2010; Jang et al., 2012). However, national studies

how BB men are providing a large amount of informal intergenerational family caregiving beyond simply caring for wives and spouses (NAC/AARP, 2009; Simmons et al., 2003). Indeed, in the present study, a majority of BB men identified as providing some form of caregiving. However, while this study was open to all BB men, participant recruiting tools included caregiver language and thus were potentially more likely to result in a higher level of recruitment of men interested in one or more aspects of caregiving, likely due to current identification as caregivers. Therefore, the author cannot make assumptions about the extent to which the sample represents how much caregiving BB men as a whole are providing. When the means of psychological distress of caregiving BB men were compared to non-caregiving BB men, the current study found caregivers only reported slightly more distress, but this difference was not statistically significant. Psychological distress in the current study had a strong positive relationship with perceptions of discrimination and a strong negative relationship with identifying as heterosexual and White/Caucasian, which is consistent with previous research findings relating to distress caused by discrimination (e.g., Hulko, 2009; Witten, 2009). Psychological distress also had a strong positive relationship with amount of ADL provided and a moderate positive relationship with amount of IADL provided, which is also consistent with previous research findings relating to caregiver stress (Robertson et al., 2007).The present study was not able to differentiate between general psychological distress and the psychological distress of caregiving.

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The present study focused on four categories of discrimination that have been

well established as negatively impacting self-esteem and life satisfaction and thereby

creating psychological distress: ageism (e.g., Garstka et al., 2004; North & Fiske, 2012;

Rozanova, Northcott, & McDaniel, 2006); classism (e.g., Bullock & Limbert, 2003;

Copen, 2006; Hunt, 2004; McManus, Anderberg, & Lazarus, 2007; Mock, Sedlovskaya,

& Purdie-Vaughns, 2011; Shildrick & MacDonald, 2013); heterosexism, biphobia, and

transphobia (e.g., Chapple, Kippax, & Smith, 1998; Weiss, 2003; Witten, 2009; Witten &

Eyler, 1999); and racism (e.g., Federal Bureau of Investigation, 2011; Flippen & Tienda,

2000; Huber et al., 2008; Lee & Ahn, 2011, 2012, and 2013; Pieterse et al., 2012).

Results of the present study found that at least some BB men reported perceiving

discrimination consistent with one or more of these categories at the present time. The

qualitative aspect of these questions allowed the author to capture the experience of six

BB men who also reported other aspects of perceived discrimination, such as their weight

or their status as a widower; the experiences of these participants are similar to previous

research findings that various facets of physical appearance (Zinn & Dill, 1996) or other

aspects of social identity (Cole, 2009) can also be potential sources of perceived

discrimination.

In the current study, caregivers reported greater perceptions of discrimination than

non-caregivers even though the results were not statistically significant. The lack of

significance maybe due to not having a large enough sample from each group. Previous

findings on the resilience or support that caregiving (Connell & Gibson, 1997; Crewe,

2007; Foley et al., 2002, Hammer & Neal, 2008; Holland et al., 2010; Miller, 1981) maybe found in larger samples. Caregiving BB men reported they perceived their age, education, race, "other form of discrimination not listed," and sexual orientation/gender identity in descending order to be their primary source of discrimination. In contrast, non-caregivers listed the primary reason for their perceived discrimination as race, age, education, and sexual orientation and "other form of discrimination not listed" in descending order. The present study did not explore the relationship between caregiving, non-caregiving, and discrimination. The sample size was not large enough to run analyses on different demographic categories of men. The caregiving BB men in the current study's sample may have shown more resilience to discrimination due to the impact of being part of a social support network either through relationships, work, or having a positive self-concept or sense of self-esteem, and may have an internal ability to apply problem solving (e.g., Bowleg et al., 2003; Lee & Ahn, 2012, Molero et al., 2011). These factors may alleviate some of the perceptions of distress caused by potential pressures of discrimination.

The study did not find a statistically significant relationship between discrimination and the impact on the number of ADLs provided by caregiving BB men. Caregiving men appeared to provide fewer ADLs than women (del-Pino-Casado et al., 2012; NAC/AARP, 2009), yet previous research had not attempted to explore the relationship between performance of ADLs and perceived discrimination. There was also no statistically significant relationship between perceptions of discrimination and the

number of hours per week providing care. Previous research showed that men do provide

weekly care to care recipients, yet little research appeared to have focused on men and or

explored the relationship of discrimination with caregiving (e.g., Bonnet, Cambois,

Cases, & Gaymu, 2011; NAC/AARP, 2009). Finally, previous research has documented

a well-established relationship between male caregivers providing more IADLs than

ADLs compared to female caregivers (e.g., Fredriksen, 1999; Hequembourg & Brallier,

2005; MetLife, 2006; Paoletti, 2002).

Although the moderation hypotheses of the present study were not supported as

evident by non-significant interactions effects, main effects were evident and a number of

simple correlations were significant. In particular, psychological distress was correlated

with discrimination ($r=.659$) the amount of ADL provided ($r=.495$), and with the amount

of IADL provided ($r=.332$). Discrimination was correlated with the amount of ADL

provided ($r=.343$) and the amount of IADL provided ($r=.312$).

The present study contributes to the previous literature in that there was at least an

attempt to acknowledge different social positions inhabited by caregiving men and the

impact of discrimination. One explanation for the lack of relationship between

discrimination and caregiving in the current study may be that nearly one-third of the

study's participants identified their ethnicity as being something other than

White/Caucasian. Previous studies have shown resilience factors in younger Black

caregivers of both genders (e.g., Connell & Gibson, 1997; Foley et al., 2002, Jordan-

Zachery, 2009), although only female White caregivers appeared to report positive

psychological effects from their caregiving roles (Foley et al., 2002). When controlling

for gender, racial/ethnic minority participants may have more experience managing

psychological distress (e.g., Bowleg et al., 2003; Burt et al., 2012; Molero et al., 2011;

Singh & McKleroy, 2010). The greater distress may be due to a lifetime of navigating a

salient marginalized component of identity. Similarly, since nearly all the non-White

participants in the current study reported intergenerational caregiving, the lack of

significant findings may reflect a normative standard for intergenerational caregiving of

non-spouse family members who were both older and younger than the caregiver in some

non-White cultures. Certain ethnic groups may place cultural value on keeping

caregiving within the family rather than delegating it to outsiders(e.g., Family Caregiver

Alliance, 2010; Simmons et al., 2003), and the impact of those cultural beliefs may have

been salient in the perceptions of caregiving reported by some participants in the current

study. While the present study attempted to recruit a more diverse sample than that

typically found in prior investigations, the majority of participants were similar to those

in previous studies and may not have captured the experiences of marginalized caregiving

men. Therefore, results cannot be generalized to all BB men nor can discrimination be

definitively ruled out as impacting caregiving experiences.

Previous studies have shown that access to respite and social support are

successful coping strategies for reducing psychological distress among caregivers (e.g.,

Perrig-Chiello & Hutchison, 2010; Steffen, McKibbin, Zeiss, Gallagher-Thompson, &

Bandura, 2002). National surveys have also found that those without resources to assist

in caregiving report more psychological distress (NAC/AARP, 2009). Social support has also been shown to decrease the impact of racial discrimination on psychological distress (Lee & Ahn, 2012 and 2013).However, the present study did not find a relationship between psychological distress and respite ($r=-.183$) or between psychological distress and social support ($r=.072$). One explanation for this finding may be that most of the existing research on caregivers has focused on women, and thus normative data about caregiving is based on women's experiences rather than men's (e.g., Hammer & Neal, 2008; Miller, 1981). Current literature (e.g., Mitchell & Knowlton, 2009) has consistently identified social support and openness about caregiving roles as coping mechanisms for decreasing psychological distress in female caregivers, but it is unknown whether or not these manifest as coping mechanisms for male caregivers as well. While BBs find satisfaction in civil engagement (Malone, Beach &Langeland, 2011; Twenge et al., 2012), BB men may not have framed caregiving as a source of civil engagement.

The current study did not capture data that might identify sources of social resilience for caregiving BB men, which may be different than those previously identified as salient for caregiving women. Another explanation for not finding a relationship between respite, social support, and distress may be due to gender role conflict (GRC) for men. GRC encompasses incongruent feelings created when internalized traditional male socialization messages, such as needing to be the breadwinner or to be aggressive, intersect with current roles, such as nurturer or caregiver (e.g., Mahalik et al., 2001; O'Neil et al., 1986).O'Neil (2008) has found the GRC in men minimizes their ability to

show emotion and affection, especially to other men. These gender role conflicts also occur when men deviate from socially understood gender roles, a phenomenon that certainly applies to men taking on caregiving roles (Doucet, 2006; Mahalik et al., 2001). Gender role conflict may have caused underreporting and/or underutilization of support within men who reported some caregiving roles. For example, traditional male socialization promotes restricted emotionality and stigma for non-traditional roles. Male caregivers who experience high GRC may have been reluctant to admit to using help or may utilize a different language around utilization of supports. The current study may not have clearly differentiated social support for the sample or allowed participants to provide their own examples of how others may assist them in their caregiving role.

Implications for Theory

The present study sought to explore how different aspects of identity inform and promote individuals' roles and perceptions for a specific demographic group, caregiving BB men. The framework used was feminist gerontology (Calasanti, 2004; Iwasaki, Bartlett, MacKay, Mactavish, & Ristock, 2008; Paoletti, 2002). This feminist perspective on aging allows for an understanding of different experiences within a life course framework, including recognition of external influences, such as discrimination (Hooyman et al., 2002). Feminist gerontology incorporates the theory of intersectionality acknowledging that social location changes people's behavior and perceptions, including gender socialization and expectations (Hulko, 2009; Iwasaki et al., 2008).

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The current study explored aspects of identity related to caregiver status and discrimination (e.g., racism, ageism, classism, and heterosexism). Results of the study suggested that these aspects of identity do impact overall psychological distress for Baby Boomer men, but were mostly unrelated to either the type or amount of caregiving behavior provided by participants, except for a moderate negative relationship between amount of ADL provided and identifying as White (r=-.342).White men may be providing less ADL than men of color due to power differentials of providing alternate, less hands-on care such as financial, planning, or transportation support (e.g., del-Pino-Casado et al, 2010; Haefele, 2010; Hequembourg & Brallier, 2005; MetLife, 2006; Paoletti, 2002). The lack of significant correlations between the aspects of identity studied and caregiving behavior may be at least partially influenced by the researcher's attempt to conduct the study utilizing a feminist approach in which an attempt was made to capture perceptions of discrimination as a form of negative societal expectations. In the current study, although the caregiver participants did report perceiving discrimination, especially discrimination related to their age, there did not appear to be a relationship between the experiences of perceived discrimination and the type or amount of caregiving provided.

Feminist gerontology tenets could be expanded by including dialogue about experiences of male caregivers and related social interactions across the life course (Calasanti, 2004). Feminist gerontology may need to re-address gender's social construct. A gender role conflict model may better account for psychological distress

that current social trends may have on men (Calasanti, 2004; O'Neil, 2008). Feminist gerontology integrates a recognition of socio-political influences, such as discrimination (Freixas, Luque, & Reina, 2012; Hooyman et al., 2002). Aging men experience several changes in their social location, including changes in income due to retirement or quasi-retirement, changes in household make-up related to intergenerational caregiving, and concepts of self as aging. These changes impact an individuals' behavior and perceptions (Hulko, 2009; Iwasaki et al., 2008). Theory can evolve to explore how these aspects of identity intersect to increase marginalization of aging men, including how longevity may impact gender socialization and expectations.

Theories about caregiving stress could be modified to include male caregivers, older caregivers, and marginalized caregivers. Existing research examining caregiver stress provided only limited categories of distress, and those categories of distress identified may be more applicable to female caregivers than to male caregivers (e.g., Black et al., 2010; Bonnet et al., 2011; Crewe, 2006; King et al., 2009; Letiecq et al., 2008; O'Rourke et al., 2007). Additionally, theories about who provides care should be more inclusive and less exclusive in their assumptions above male providers of intergenerational caregiving (e.g., Connell & Gibson, 1997; Foley et al., 2002; Jordan-Zachery, 2009; NAC/AARP, 2009).

Implications for Research

Researchers who wish to advance the scholarship in the area of caregiving men and psychological distress should take into consideration various elements of social

placement, such as socioeconomic status (SES) and retirement status, in addition to the caregivers' concept of support. The current study did not find a relationship between discrimination, caregiving roles, and psychological distress, but it cannot be definitively said that no relationship exists. The current study's design was primarily influenced by an empirical base of research on caregivers; this base has largely consisted of research conducted on female caregivers. Male socialization in the United States (U.S.) values and rewards success, competition, and work over family, while devaluing men showing affection to other men (Brooks & Silverstein, 1995). One explanation for the lack of support for the hypotheses about discrimination and caregiving in the current study may be the impact of traditional patriarchal history in the U.S. Men may have low expectations and perceptions of their own distress and therefore underreport caregiving stress (O'Neil, 2008). The same may apply to men's understanding of, acknowledgement of, and even language about social support.

The present study attempted to rectify some of the gaps in previous caregiving research by developing a study based on theory and using advanced statistical analysis. Dilworth-Anderson, Williams, and Gibson's (2002) meta-analysis of caregiving research found many previous studies had weak designs, were poorly anchored in theory, or used inconsistent measures. Future research could take into account research design beyond correlational analysis to explore more cause and effect interactions for caregiving men's psychological distress and various moderating and mediating factors, such as access to resources, social location, and definition of caregiving. The utilization of alternative

research designs, such as qualitative studies, would contribute to the scope of knowledge by capturing personal examples of intersectionality of various factors and could also provide a more explicit focus on non-dominant culture male care providers.

Future research should also investigate whether the SES of caregiving men impacts psychological distress. Access to respite may be greatly influenced by SES when alternative family members are not available, since caregivers are often those with lower SES (e.g., Burnette, 1999; Furstenberg Jr., 2010; Minkler & Fuller-Thompson, 2000; Simmons, Dye, & Bureau of the Census, 2003; U.S. Bureau of the Census, 2011b). Future research designs should also utilize more inclusive language to capture how participants understand support for caregiving roles. Inclusive language around sexual orientation and gender presentation should be acknowledged. Improvements could be made in studies attempting to recruit diverse participants to allow marginalized participants to understand the purpose of the study and application of findings. If studies and their results are perceived to be more accessible by marginalized potential participants, those individuals may indeed be more likely to participate. Additionally, survey formats could include more inclusive language to allow for participants to identify themselves. These improvements can assist in a more holistic understanding of participants' experience. The present study attempted to use the Internet with inclusive language in recruitment materials and in demographic categories because previous studies did not capture minority participants unless these groups were specifically targeted.

Specifically, further studies should investigate the relationship between caregiving men and how they define social support. Additional research might also explore the impact of relational status on the possible division of caregiving tasks. Partner status is important to look at because as previously mentioned, men typically provide few ADLs and more IADLs (NAC/AARP, 2009). Identifying participants' partner status may help clarify the relationship between caregiving roles and amount of caregiving for older, diverse men. Future research could involve an expansion of feminist gerontology to explore the intersectionality of personal aspirations, family expectations, and access to resources for men who are in retirement.

Attempting to recruit participants for the present study proved challenging and may be one of the reasons a caregiving BB population is understudied. Future researchers may consider collecting data from a variety of sources, including national caregiving support organizations, retirement organizations, and directly in communities of interest. A larger and more diverse sample would aid in better the generalizability of the results to the overall population. However, participants in the current study were primarily White, financially secure, and educated; this demographic breakdown of participants was largely consistent with previous studies lacking research questions or recruitment targeted to diverse populations (e.g., Albert et al., 2010; Black et al., 2010; Finkelstein et al., 2012; Gamarel et al, 2012; Piercy & Chapman, 2001) and suggested that inclusive recruitment language alone is insufficient to ensure a diverse sample. Future studies of intergenerational caregiving in non-dominant cultures may find that

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these cultures differ from the dominant culture in terms of their expectations around

caregiving, as supported by prior studies on grandparents caring for their grandchildren

(i.e., Simmons et al, 2003; U.S. Bureau of the Census, 2012). Further, while the Internet

was utilized to recruit participants in an attempt to capture a more diverse sample,

minority participants were still not obtained. The lack of minority participants and the

dominance of higher SES, White, educated men may be due to a difference in degrees of

access to the Internet. The most recent national census has shown that only 27% of the

U.S. population has easy access to the Internet, with those who identify as White being

1.3 times more likely to connect than Black individuals, and households reporting higher

educational attainment and higher annual incomes tended to be the most connected (U.S.

Bureau of the Census, 2013).

Implications for Practice

As more BBs move into retirement, find themselves in caregiving roles, and face

their own aging, financial stress and age discrimination will create an increased demand

for counselors to be educated about gerontological issues and related social concerns

(Maples & Abney, 2006; Nelson, 2005). Karel, Gatz, and Smyer (2012) predicted that

BBs may be less resilient than previous generations due to the changing environment of

aging-related medical, functional, and financial stresses. Greater understanding of how

caregiving men navigate internal and external stress would assist mental health providers

in providing support and might also help in forming resource networks in BB men's

communities.

The 2014 update to the *Guidelines for Psychological Practice with Older Adults* (American Psychological Association) emphasizes the importance of addressing the clinical needs of an aging population. One dialogue that could prove useful in assisting mental health providers in engaging older clients involves recognizing the strengths and changing roles of older men, including members of the Baby Boomer cohort who are or will be providing intergenerational care to one or more family members. Therapists are well-positioned to provide interdisciplinary consultation, family and systems supports, and psychoeducation on aging to older caregiving men, provided that they utilize the current knowledge base on working with these clients appropriately. For example, therapists can work to challenge negative stereotypes on aging, expanding older caregiver clients' use of proven resilience factors, such as maintaining interpersonal connections, assist clients in exploring the biopsychosocial aspects of aging, and help clients identify and manage the differences between natural aging processes and pathological ones, such as dementia. In the current study, many BB men reported not only being in a caregiving role, but also experiencing some psychological distress and subjective experiences of ageism.

Understanding men are providing care may inform the practice of mental health, social services, and consultation to the medical community. Participants in the current study reported experiencing psychological distress whether they are caregivers or not. Counselors can work to ameliorate BB men's psychological distress, by promoting healthy coping strategies and normalizing the aging process (North & Fiske, 2012).

Counselors can also assist BB men in addressing family expectations regarding gender roles and caregiving (O'Neal, 2008). Baby Boomer men also face systemic pressures as they grow older, including society's unrealistic views of aging. Normal older adult functioning is often pathologized by both the media and pharmacological companies. Therapists could include normalize aging for both aging individuals and their families (Laidlaw & Baikie, 2007).

In addition to educating clients about aging, counselors could advocate for better communication between BB caregivers and community resources that may be available to them, such as formal elderly caregivers. Previous studies have shown that women have been the primary providers of ADL caregiving (e.g., del-Pino-Casado et al., 2012; NAC/AARP, 2009) so men may have been excluded as the target for marketing, networking, and recruiting from services, such as respite companies, in-home nursing support, or other resources aimed at caregivers. Increasing communication and support between medical and psychological professionals and family caregivers is important for the overall health of the caregiver and might minimize the chance of elderly abuse by caregivers who are overburdened or stressed (Nelson, 2005).

There are also high risks for all caregivers of suffering burnout from compassion fatigue and/or their own declines in psychological and physical health (Terry, 2008). Counselors can work to de-stigmatize and normalize the feeling of helplessness and dependence BB men caregivers may experience (Terry, 2008) as well as help connect these men to resources that may be beneficial for them. The current study targeted older

men specifically and was not able to incorporate these caregivers' perceptions of themselves as being elderly or if they also considered themselves in need of care. Counselors working with families and individuals could address unique needs and resources for different systems as they change and evolve.

Counselors can increase their awareness of systemic issues beyond just assisting individual BBs. Counselors can create social change through participating in the community and disseminating information on caregiving; through these venues, they may also access and assist those BB men who do not come in for individual therapy. As BB men get older, they may choose to exert independence and self-reliance by not seeking help or support, especially BB men used to being in positions of power or status (Calasanti, 2004). Counselors can work with service providers, communities, as well as individuals to decrease men's resistance to help seeking by increasing education on the benefits of support, decrease stigma for those seeking support, and to open dialogue on barriers to help seeking. Black men, despite being at higher risk of health concerns as they age relative to White men, were less likely than other older White men to seek help from doctors or other health providers (Calasanti, 2004), which may reflect stronger masculine gender role socialization. Counselors can increase their education and consultation in multicultural domains to better assist different levels of concern and resistance that their community.

Limitations

Reflection is important to acknowledge limitations in study design and execution. While surveys do allow a large number of participants to be approached, there are some biases inherent in accessing solely participants who have access to computers and the Internet, including coverage and sampling errors. "Coverage error refers to the unknown proportion of BGLT [and other marginalized groups] target persons who do not have online access. Sampling error, on the other hand, refers to the failure to sample from all of those who do have online access [*sic*]" (Riggle, Rostosky, & Reedy, 2005, pp. 2-3). All participants in the current study therefore had some access to the resources (i.e., money to purchase technology or access to technology as well as the time to spend on an online survey) as well as the ability to find and participate in an online survey. Therefore, men with a lower SES and/or less technical acumen were likely excluded. Future studies may wish to consider utilizing a mixed strategy of online and paper recruiting and surveys to increase access to those men.

The researcher would also like to acknowledge the limitations and biases inherent in the author's and most of the references' Western focus. While the author attempted to use inclusive language and recruited participants from online sources, bias and presumption continue to be present based on what questions were and were not asked; for example, the researcher did not ask about participants' living situation (e.g., urban versus rural) or their marital status. Most of the Western research referenced in the current study most likely had an individualistic frame of reference that the present study did not

acknowledge or attempt to challenge. Minority groups within the U.S. may maintain a collectivist culture and thus may have felt excluded, invalidated, or even discouraged from participating in the present study.

The choice of statistical analysis can present additional limitations for any study. The measures for the current study are rather distal from the constructs of primary interest in understanding the various perspectives of caregiving BB men in different psychosocial locations, such as differing perceptions of discrimination and distress. The use of a regression analysis limits interpretations to ascertaining the existence of a relationship among a given set variables, but does not allow for a deduction of causality between those same variables (Aiken & West, 1991; Osborne & Waters, 2002).Therefore, even though caregiving roles, hours a week caregiving, and discrimination correlated with psychological distress, the ability to explain what directly causes more or less distress cannot be determined.

Conclusion

Baby Boomer men in this study clearly reported psychological stress and endorsed providing intergenerational caregiving, yet they have had little voice in the conversation about caregiving, whether that be in the scholarly literature or amongst the general public. Findings remain uncertain about how a myriad of variables may or may not impact men's caregiving experiences, particularly non-dominant culture men. While the current investigation provided some steps in the right direction, additional future studies will be critical in telling the important story of older caregiving men.

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APPENDIX A

Demographics and General Information

Demographics Questionnaire

1) Birth year _____

2) Sexual orientation:

      _____ Heterosexual
      _____ Gay
      _____ Bisexual
      _____ Questioning

3) Gender:
      _____ Man
      _____ Transgender man/Transgender Female-to-Male

4) Ethnicity:
      _____ American Indian/Alaskan Native
      _____ Black/African American
      _____ East Asian/ Asian American
      _____ Latino/Hispanic
      _____ Middle Eastern/West Asian
      _____ Native Hawaiian/Pacific Islander
      _____ South Asian/Asian Indian
      _____ White/Caucasian
      _____ Biracial/Multiracial/Multiethnic

5) Years of education: _____

6) Yearly Income (from all sources): _____

7) For whom are you providing care? (check all that apply):
      _____ Your parent(s)
      _____ Your partner's parent(s)
      _____ Your child (son or daughter, children)
      _____ Your partner's child (children)
      _____ Your grandchild (grandchildren)
      _____ Your partner's grandchild (grandchildren)
      _____ None of the above

Note: If the participant says "None of the above" the survey will thank them for participation, forward to incentive page then terminate.

8) How long have you provided care? ___ months, ____ years

9) On average, how many hours a week are you providing care? _____ hours a week

10) How sure are you that someone else could care for your family member if you needed
     to step away for several hours to a day or two?

_____
| 1 | 2 | 3 | 4 | 5 |
| Not sure at all | | Maybe yes/Maybe no | | Certain |

11) How would you say your health is these days?

_____
| 1 | 2 | 3 | 4 | 5 |
| Very good | Good | Neutral | Poor | Very Poor |

APPENDIX B

The Hopkins Symptom Checklist-58 (HSCL-58)

The Hopkins Symptom Checklist-58 (HSCL-58)

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please rate how much that problem has bothered you during the last week (7 days), including today.

1	2	3	4
Not at all	A little bit	Quite a bit	Extremely

How much are you bothered by:
1. Headaches
2. Nervousness or shakiness inside
3. Being unable to get rid of bad thoughts or ideas
4. Faintness or dizziness
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. Bad dreams
8. Difficulty in speaking when you are excited
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in the heart or chest
13. Itching
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Sweating
17. Trembling
18. Feeling confused
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. A feeling of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts you could not control
25. Constipation
26. Blaming yourself for things
27. Pains in the lower part of your back
28. Feeling blocked in getting things done
29. Feeling lonely
30. Feeling blue
31. Worrying too much about things

32. Feeling no interest in things
33. Feeling fearful
34. Your feelings being easily hurt
35. Having to ask others what you should do
36. Feeling others do not understand you or are unsympathetic
37. Feeling that people are unfriendly or dislike you
38. Having to do things very slowly to insure correctness
39. Heart pounding or racing
40. Nausea or upset stomach
41. Feeling inferior to others
42. Soreness of your muscles
43. Loose bowel movements
44. Trouble falling asleep
45. Having to check and double check what you do
46. Difficulty making decisions
47. Wanting to be alone
48. Trouble getting your breath
49. Hot or cold spells
50. Having to avoid certain things, places or activities because they frighten you
51. Your mind going blank
52. Numbness or tingling in parts of your body
53. A lump in your throat
54. Feeling hopeless about the future
55. Trouble concentrating
56. Feeling weak in parts of your body
57. Feeling tense or keyed up
58. Heavy feelings in your arms or legs

APPENDIX C

Instrumental Activities of Daily Living Scale

Instrumental Activities of Daily Living Scale

For each category, choose the item describing the assistance most closely resembling the

care you provide for your family member(s); either 0 or 1.

A. Ability to Use Telephone

    1. The person you care for can operate the telephone without any help; such as

       looking up and dials numbers (expect for young grandchildren) 0

    2. _____ can use the telephone with assistance or does not use telephone at all; you

       provide assistance with telephone calls 1

    3. _____does not use telephone at all; someone else provides help with telephone

       calls 0

B. Shopping

    1. The person you care for takes care of most shopping needs independently or is too

       young to shop on their own... 0

    2. You need to accompany your parent or adult child on any shopping trip 1

    3. Older grandchild or adult care recipient is completely unable to shop, so you do

       some or all of the shopping... 1

    4. Your care recipient needs to be accompanied or is unable to shop and someone else

       does the shopping.. 0

C. Food Preparation

    1. Your care recipient can plans, prepares, and serves adequate meals independently;

       if you care for grandchildren, they assist age appropriately 0

2. You assist in making meals for _____ 1

3. Another person assists in making meals for _____ 0

D. Housekeeping

1. _____is able to maintain house (or child's bedroom) alone with occasion

assistance (heavy work) 0

2. _____does not do any housework (except for very young grandchildren), and

you do some or all of housekeeping 1

3. _____does not do any housekeeping, and another person assists in most or all the

housekeeping.. 0

E. Laundry

1. _____does some or all of personal laundry (except for grandchildren) 0

2. You assist with most or all laundry that your care recipient needs (except for young

grandchildren) 1

3. Another person assists or does all of __ ___'s laundry 0

F. Transportation

1. _____ is able to travels independently on public transportation or drives own car

(grandchildren are capable to ride school bus if they needed to) 0

2. _____ travels with your assistance 1

3. _____ travels with someone else's assistance 0

G. Responsibility for Own Medications

1. Adult recipient is able to taking medication in correct dosages at correct time .. 0

2. Grandchild will take their medication when you prepare it or as they have been

    permitted by doctors 0

3. You prepare all medication in separate dosages in advance and/or you have to

    dispense medication for _____ 1

4. Someone else prepares and/or dispenses medications for _____ 0

H. Finances

1. Adult care recipient is mostly able to manages financial matters independently

    (budgets, writes checks, pays rent and bills, goes to bank) 0

2. Grandchildren can manage their allowance and/or understands the costs of the

    items they want (such as movies, games, cell phone, etc.)................................ 0

3. _____ is incapable of handling money (age appropriately), you manage most or all

    of _____'s finances and/or you provide financial support for _____ 1

4. ___ is incapable of handling money (age appropriately), someone else manages

    most or all of __'s finances and/or provides ___ with financially assistance....... 0

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APPENDIX D

Activities of Daily Living

Activities of Daily Living

For each category, choose the item describing the assistance most closely resembling the care you provide for your family member(s); either 0 or 1.

A. Bathing

0....._____bathes self completely (except very young grandchildren) or needs help in bathing only a single part of the body or an area due to a physical disability.

1....._____needs help with bathing more than one part of the body, getting in or out of the tub or shower and/or requires total bathing assistance – you provide assistance.

0....._____needs assistance bathing and someone else assists.

B. Dressing:

0....._____gets clothes from closets and drawers and puts on clothes and outer clothes complete with fasteners (age appropriate for young grandchildren).

1....._____needs help with dressing self or needs to be completely dressed (older grandchildren or adults) – you provide assistance.

0....._____needs help dressing and someone else assists.

C. Toileting:

0.....____goes to toilet, gets on and off, arranges clothes, cleans genital area without help (except for very young grandchildren).

1....._____needs help getting on and off the toilet, cleaning self or using bedpan or commode – you provide assistance

0....._____needs toilet assistance and someone else assists

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D. Transferring:

0....._____moves in and out of bed or chair unassisted by another person (except for very

young grandchildren).

1....._____needs help in moving from bed to chair or requires a complete transfer – you

provide assistance.

0....._____needs help moving from bed to chair or requires a complete transfer and

someone else assists

E. Feeding:

0....._____is able to take care of feeding self without assistance (except for very young

grandchildren).

1....._____needs partial or total help with feeding or requires special feeding equipment

like a feeding tube – you provide assistance.

0....._____needs partial or total help with feeding or requires special feeding equipment

and someone else assists

APPENDIX E

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Publisher of your work	n/a
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APPENDIX F

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APPENDIX G

The Everyday Discrimination Scale

The Everyday Discrimination Scale

In your day-to-day life, how often do any of the following things happen to you?

0	1	2	3	4	5
Never	Less than once a year	Few times a year	A few times a month	At least once a week	Almost everyday

1. You are treated with less courtesy than other people are.
2. You are treated with less respect than other people are.
3. You receive poorer service than other people at restaurants or stores.
4. People act as if they think you are not smart.
5. People act as if they are afraid of you.
6. People act as if they think you are dishonest.
7. People act as if they're better than you are.
8. You are called names or insulted.
9. You are threatened or harassed.

Follow-up Question (Asked only of those answering 3 or more to at least one question.):

What do you think is the main reason for these experiences?

(0-does not apply to me, 1-a main reason, 2-a secondary reason)

A. Your Age
B. Your Race/Ethnicity
C. Your Sexual Orientation or Gender Presentation
D. Your Education or Income Level
E. Other

Note: This instrument may be obtained from Williams, D.R., Yu, Y., Jackson, J.S., and

Anderson, N.B. (1997). Racial differences in physical and mental health: Socioeconomic

status, stress, and discrimination. *Journal of Health Psychology, 2*, 335-351. Retrieved

from

http://scholar.harvard.edu/files/davidrwilliams/files/measuring_discrimination_resource_f

eb_2012_0.pdf

APPENDIX H

Communications with Dr. Williams on the Everyday Discrimination Scale

RE: The Everyday Discrimination Scale
Williams, David [dwilliam@hsph.harvard.edu]
Sent: Monday, September 09, 2013 7:42 PM
To: Nardecchia, Angela
Attachments:

No permission necessary

E-mail remains an inefficient way to reach me. Lengthy delays in responding to messages
are routine. Please copy Maria Simoneau (msimonea@hsph.harvard.edu) on important e-
mail messages. We will be back in touch with you just as soon as we can.

David R. Williams
(http://scholar.harvard.edu/davidrwilliams/)
Florence Sprague Norman & Laura Smart Norman Professor of Public Health
Professor of African and African American Studies and of Sociology
Director, Lung Cancer Disparities Center http://lcdc.sph.harvard.edu/
Co-Leader, Cancer Risk Reduction and Disparities Program, Dana Farber/Harvard
Cancer Center
Harvard University

Address: Harvard School of Public Health
Department of Social and Behavioral Sciences
677 Huntington Ave, 6th Floor
Boston, MA 02115

Tel. 617-432-6807
Fax 617-432-3755

"THE GREATEST EVIL is not done in those sordid dens that Dickens loved to paint, but
is conceived and ordered (moved, seconded, carried, and minuted) in clear, carpeted,
warmed, well-lighted offices, by quiet men with white collars and cut fingernails and
smooth-shaven cheeks who do not need to raise their voices." C.S. Lewis

-----Original Message-----
From: Nardecchia, Angela [mailto:anardecchia@mail.twu.edu]
Sent: Monday, September 09, 2013 8:26 PM
To: Williams, David

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Subject: The Everyday Discrimination Scale

Dear Dr. Williams,

I have read about the Everyday Discrimination Scale in your article "Racial differences in physical and mental health: Socioeconomic status, stress, and discrimination" and from your Measuring Discrimination Resource Harvard resource PDF. I am working on my dissertation for my Ph.D. in Psychology and your scale looks very promising for my research. I have not been able locate any additional information on requesting permission to use or purchase your scale. Thank you for any information you can provide.

Take care,

Angela Nardecchia, M.A.
Counseling Psychology Doctoral Student
TWU Department of Philosophy and Psychology

APPENDIX I

Perceived Social Support for Caregivers

Perceived Social Support for Caregivers

_____

0	1	2	3	4
Not at all	Almost never	Sometimes	Fairly often	Very often

1. I can talk over my feelings about caregiving with others who have similar values.

2. Others I know have helped me deal with frustrations I have as a result of being a

   caregiver.

3. Others I know have given me useful advice about how to plan for the future.

4. Others have helped me gain insight into my behavior and feelings as caregiver.

5. I know someone who understands the difficulties I face as a caregiver.

6. Others I know have given me information about the concerns of my family member

   receive my care.

7. Others I know have helped me realize my problems are not unique.

8. I've learned from others I know by watching how they manage stress.

9. Overall, I feel satisfied with support I receive from others as I take care of my relative.

This instrument may be obtained from Goodman, C., & Goodman, C. C. (1991).

Perceived social support for caregiving: Measuring the benefit of self-help/support group

participation. *Journal of Gerontological Social Work, 16*, 163-175.

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APPENDIX J

Solicitation Request

Greeting,

My name is Angela Nardecchia, I am a doctoral candidate at Texas Woman's University and I am working on my dissertation under Sally D. Stabb, Ph.D. who is a faculty member in the Department of Counseling Psychology at Texas Woman's University. I am seeking your participation for my research study, Caregiving Baby Boomer Men: An Exploration of the Impact of Discrimination on Psychological Distress and Caregiving Roles. This research project seeks to explore the experiences and perceptions of discrimination by Baby Boomer men who are informal family caregivers.

Participants in this research study must meet the following criteria:
(a) born during 1946-1964 and
(b) be a man (natal or transgender)

As a token of my appreciation for your time, you can choose between a donation made to a charity or a small compensation for your time made to you.

- For a charity donation of $1 (your choice of the Alzheimer's Association, MD Anderson Cancer Research, or Human Rights Campaign) please select the PsychData link.
- For compensation ($1.09), please select the Mechanical Turk link.

The researcher will not collect any contact information from you and will strive to maintain your confidentiality/privacy. This survey is voluntary and will take you approximately 30 minutes to complete. If you are interested in participating in this important study, you may access the informed consent letter and survey at the following link:

To contribute to a charity -http:www.psychdata.com and enter survey #158805 as prompted near the top right of the page
or
To receive compensation for your time - https://www.mturk.com and access the Baby Boomer Men survey

Please feel free to pass on these links to other Baby Boomer men who might be eligible. If you have any additional questions, please feel free to contact me at anardecchia@twu.edu or Dr. Stabb at sstabb@mail.twu.edu. This research has been approved by Texas Woman's University Institutional Review Board (IRB Protocol #17542, 940-898-3378 or via email at IRB@twu.edu).

Sincerely,
Angela Nardecchia, M.A., Doctoral Candidate
Texas Woman's University

APPENDIX K

Informed Consent

Texas Woman's University
Informed Consent to Participant in Research

Title: Caregiving Baby Boomer Men: An Exploration of the Impact of Discrimination on Psychological Distress and Caregiving Roles

Investigator: Angela Nardecchia, M.A...............anardecchia@twu.edu   940/898-2303
Advisor: Sally D. Stabb, Ph.D. ....SStabb@mail.twu.edu   940/898-2149

Texas Woman's University, Department of Psychology and Philosophy

<u>Explanation and Purpose of Research</u>
You are being asked to participate in a research study for Ms. Nardecchia's dissertation at Texas Woman's University. The purpose of this research is to investigate the impact of various types of discrimination on informal family caregiving roles and psychological distress on Baby Boomer men (biologically male and transgender men born 1946-1964). You have been asked to participate in this study because you identify as a Baby Boomer man.
Informal family caregiving includes but is not limited to financial contributions, household management such as yard work or help making appointments, transportation assistance, helping someone in and out of bed, or bathing.

<u>Description of Procedures</u>
As a participant in this study you will be asked to spend up to 30-minutes of your time in an online survey. You will be asked a few demographic questions (such as race/ethnicity, education, and income) along with several questionnaires about your emotional and physical well-being, if you provide informal family care and the kind of care you provide, your perception of discrimination, and how you cope.

The researcher appreciates your time and commitment to the survey. Please recognize participation in this study is voluntary and you may withdraw from the study at any time by closing the web page. The researcher encourages you to complete all items, but you are free to skip those that make you uncomfortable to answer.

<u>Potential Risks</u>
The online survey will ask you several questions about your perception of discrimination. A possible risk in this study is discomfort with these questions you are asked. If you experience psychological or emotional discomfort during the survey questions, you may stop answering questions at any time. If you would like to discuss this discomfort with a mental health professional, the American Psychological Association has a free referral line that will assist you in contacting someone that is in your area (1-800-964-2000) or visit http://locator.apa.org/. This information will be provided again when you end or

finish the survey. You may take breaks during the survey and resume as long as you do not close the web page.

Potential risks related to your participation in the study may include loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. There is a potential risk of loss of confidentiality with any email, downloading, and Internet transactions. While a complete guarantee of confidentiality cannot be promised when completing a form on the Internet, a risk of a breach of security is minimal and involves no more exposure to a security threat than would otherwise be expected when using the Internet. The online survey will not be traced back to your machine by the researcher as your participation is to be confidential. In order to further protect your confidentiality, the investigator encourages you to complete the study within a private location so others may not view your information.

The researcher will try to prevent any problems that could happen because of this survey. You should let the researcher know at once if there is a problem and she will assist, however, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in the research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. You may choose the compensation for your time:

- A charity donation of $1 made by the researcher on behalf of your participation (the survey will allow you to choice between the Alzheimer's Association, MD Anderson Cancer Research, or Human Rights Campaign)
- For Mechanical Turk workers, a financial compensation made to you ($1.09)http:www.mturk.com/mturk/ and access the Baby Boomer Men survey

Questions Regarding the Study

If you have any questions about the research study, you may contact the researcher or advisor. If you have any questions about your rights as a participant in the research or the way this study has been conducted, you may contact Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via email at IRB@twu.edu. This research has been approved by Texas Woman's University Institutional Review Board (IRB Protocol #17542, 940-898-3378 or via email at IRB@twu.edu).

        To indicate your acceptance of these terms, you have read and understood the above statements, and you give your informed consent to participate, please go to http:www.psychdata.com and enter survey #158805 (to donate a dollar to charity) or go to http:www.mturk.com/mturk/ and access the Baby Boomer Men survey (to receive a little over a dollar for your participation), otherwise please exit from this survey.

APPENDIX L

Correlations of Variables

Correlations

		Sexual Orientation	Eth._White	Psych-Distress	Discrimination	IADL	ADL	Care Provider?	Hours providing care?	Health	Respite	PSSC
Sexual Orientation	Pearson Correlation	1	-.440	.396	.348	.045	.165	.288	.070	.312	-.009	-.014
	Sig. (1-tailed)		.000	.000	.000	.330	.054	.000	.248	.000	.467	.447
	N	154	154	154	154	97	97	154	97	154	97	97
Eth._White	Pearson Correlation	-.440	1	-.508	-.535	-.120	-.342	-.152	-.189	-.255	.010	-.096
	Sig. (1-tailed)	.000		.000	.000	.121	.000	.030	.032	.001	.462	.174
	N	154	154	154	154	97	97	154	97	154	97	97
Psych-Distress	Pearson Correlation	.396	-.508	1	.659	.332	.495	-.010	.070	.340	-.183	.072
	Sig. (1-tailed)	.000	.000		.000	.000	.000	.450	.249	.000	.037	.241
	N	154	154	154	154	97	97	154	97	154	97	97
Discrimination	Pearson Correlation	.348	-.535	.659	1	.312	.343	.110	.032	.267	-.114	.019
	Sig. (1-tailed)	.000	.000	.000		.001	.000	.087	.379	.000	.133	.427
	N	154	154	154	154	97	97	154	97	154	97	97
IADL	Pearson Correlation	.045	-.120	.332	.312	1	.376	.*	.295	.219	-.125	.089
	Sig. (1-tailed)	.330	.121	.000	.001		.000	.000	.002	.016	.112	.193
	N	97	97	97	97	97	97	97	97	97	97	97
ADL	Pearson Correlation	.165	-.342	.495	.343	.376	1	.*	.096	.313	-.145	.058
	Sig. (1-tailed)	.054	.000	.000	.000	.000		.000	.174	.001	.078	.285
	N	97	97	97	97	97	97	97	97	97	97	97
Care Provider?	Pearson Correlation	.288	-.152	-.010	.110	.*	.*	1	.*	.045	.*	.*
	Sig. (1-tailed)	.000	.030	.450	.087	.000	.000		.000	.290	.000	.000
	N	154	154	154	154	97	97	154	97	154	97	97
Hours providing care?	Pearson Correlation	.070	-.189	.070	.032	.295	.096	.*	1	.074	.001	-.025
	Sig. (1-tailed)	.248	.032	.249	.379	.002	.174	.000		.237	.498	.403
	N	97	97	97	97	97	97	97	97	97	97	97
Health	Pearson Correlation	.312	-.255	.340	.267	.219	.313	.045	.074	1	-.179	.007
	Sig. (1-tailed)	.000	.001	.000	.000	.016	.001	.290	.237		.039	.471
	N	154	154	154	154	97	97	154	97	154	97	97
Respite	Pearson Correlation	-.009	.010	-.183	-.114	-.125	-.145	.*	.001	-.179	1	.084
	Sig. (1-tailed)	.467	.462	.037	.133	.112	.078	.000	.498	.039		.206
	N	97	97	97	97	97	97	97	97	97	97	97
PSSC	Pearson Correlation	-.014	-.096	.072	.019	.089	.058	.*	-.025	.007	.084	1
	Sig. (1-tailed)	.447	.174	.241	.427	.193	.285	.000	.403	.471	.206	
	N	97	97	97	97	97	97	97	97	97	97	97

**. Correlation is significant at the 0.01 level (1-tailed).

*. Correlation is significant at the 0.05 level (1-tailed).

a. Cannot be computed because at least one of the variables is constant.

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APPENDIX M

IRB Approval Letter

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: January 13, 2015

TO: Ms. Angela Nardecchia
            Psychology & Philosophy

FROM: Institutional Review Board - Denton

Re: *Extension for Caregiving Baby Boomer Men: An Exploration of the Impact of Discrimination on*
       Psychological Distress and Caregiving Roles (Protocol #: 17542)

The request for an extension of your IRB approval for the above referenced study has been reviewed
by the TWU Institutional Review Board (IRB) and appears to meet our requirements for the
protection of individuals' rights.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data
collection at that agency. If subject recruitment is on-going, a copy of the approved consent form
with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval
date stamp when obtaining consent from your participants. A copy of the signed consent forms must
be submitted with the request to close the study file at the completion of the study.

This extension is valid one year from January 24, 2015. Any modifications to this study must be
submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be
notified immediately of any unanticipated incidents. All forms are located on the IRB website. If you
have any questions, please contact the TWU IRB.

cc. Dr. Daniel Miller, Psychology & Philosophy
     Dr. Sally D. Stabb, Psychology & Philosophy
     Graduate School